MHS Secure Provider Web Portal Overview

mhs™

ACCREDITED NCQA HEALTH PLAN

ambetter.

Hoosier Healthwise Health Care Program

HIP HEALTHY INDIANA PLAN

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Agenda

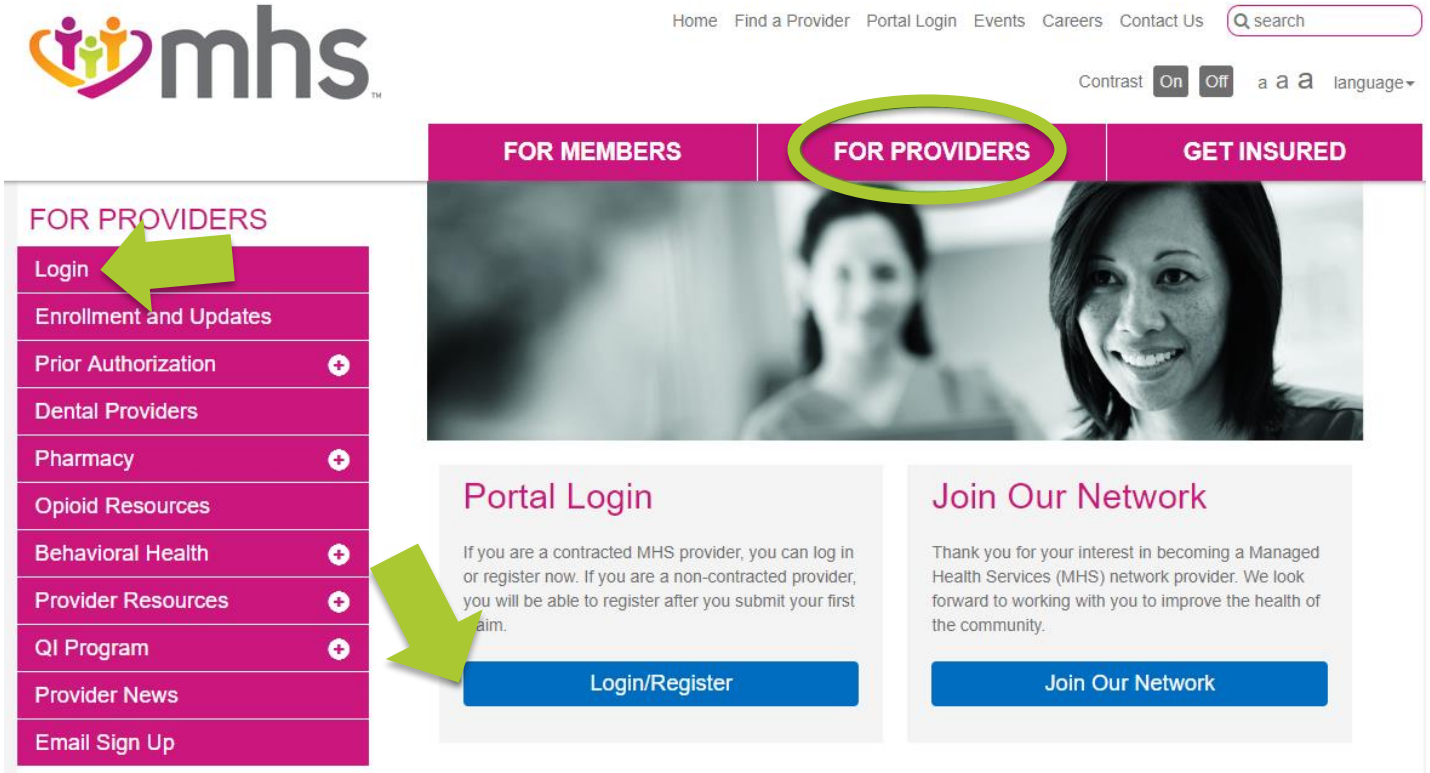
Save Time by Utilizing the MHS Secure Web Portal

- **Account Creation/Login and Training Materials**
  - Dashboard
  - MHS Member Management Forms
  - Account Details
  - Account Manager
- **Quality Reports**
  - Patient Analytics
  - Provider Analytics
- **Member Eligibility and Overview**
  - Member panel for PMPs
  - Member Record
- **Authorizations**
  - Check Status
  - Submit DME Request
- **Claims**
  - Submit, Correct and Review Claims
  - Payment History
- **Secure Messaging**

Account Creation/Login and Training Materials

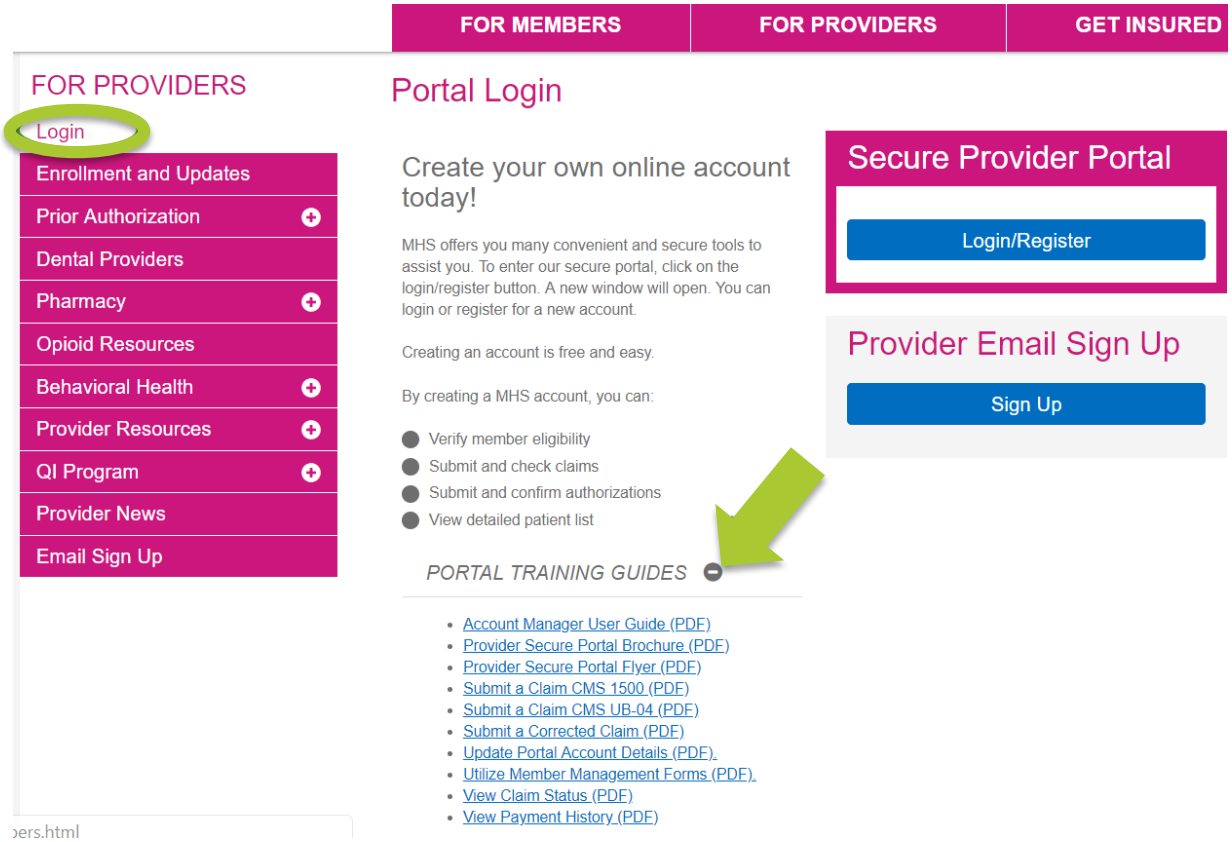
Provider Portal Login

- Go mhsindiana.com and click on **For Providers**.
- Then click **Login/Register** for the **MHS Provider Portal.**
- Click **Login** tab to view Vision/Dental Portal Login and Training Materials.



Web Portal Training Documents

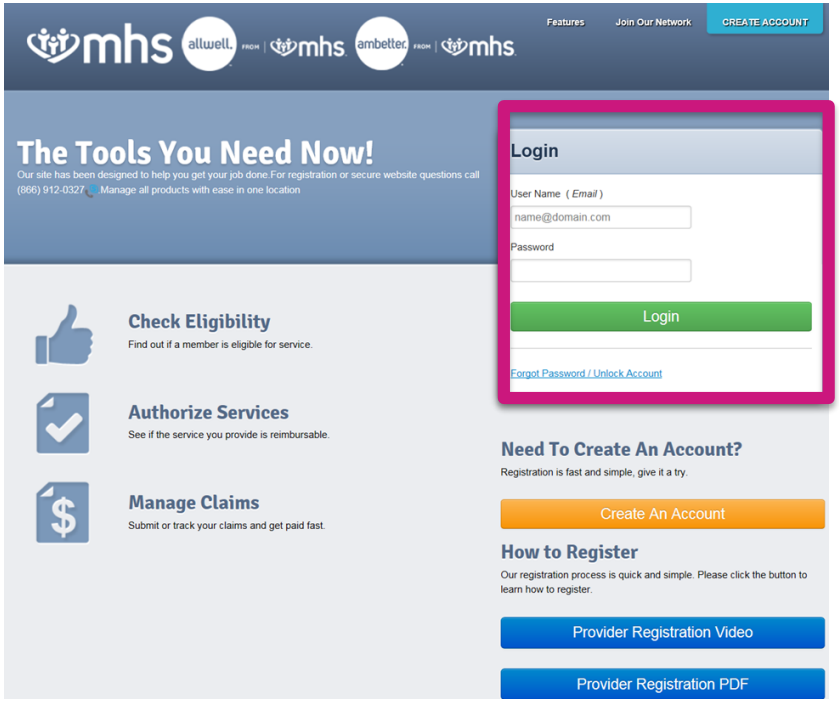
- **Login** tab contains **Portal Training Guides, Login/Register** and **Sign Up** for emails.

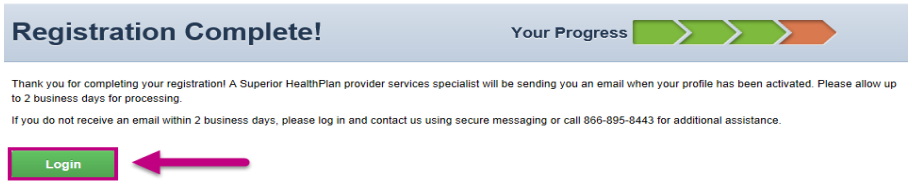


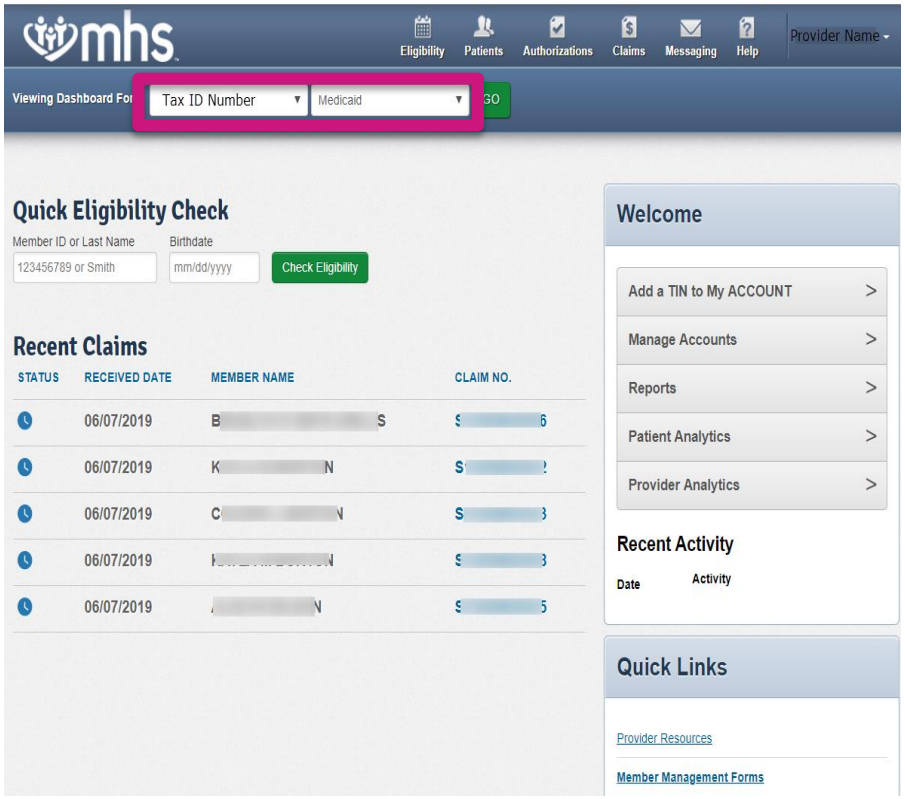
Training Documents Include:

- Account Manager Guide
- MHS Portal Brochure
- How To Guides:
  - Submit Claims
  - Correct Claims
  - View Payment History
  - Use Member Management Forms

Complete Portal Registration or Login

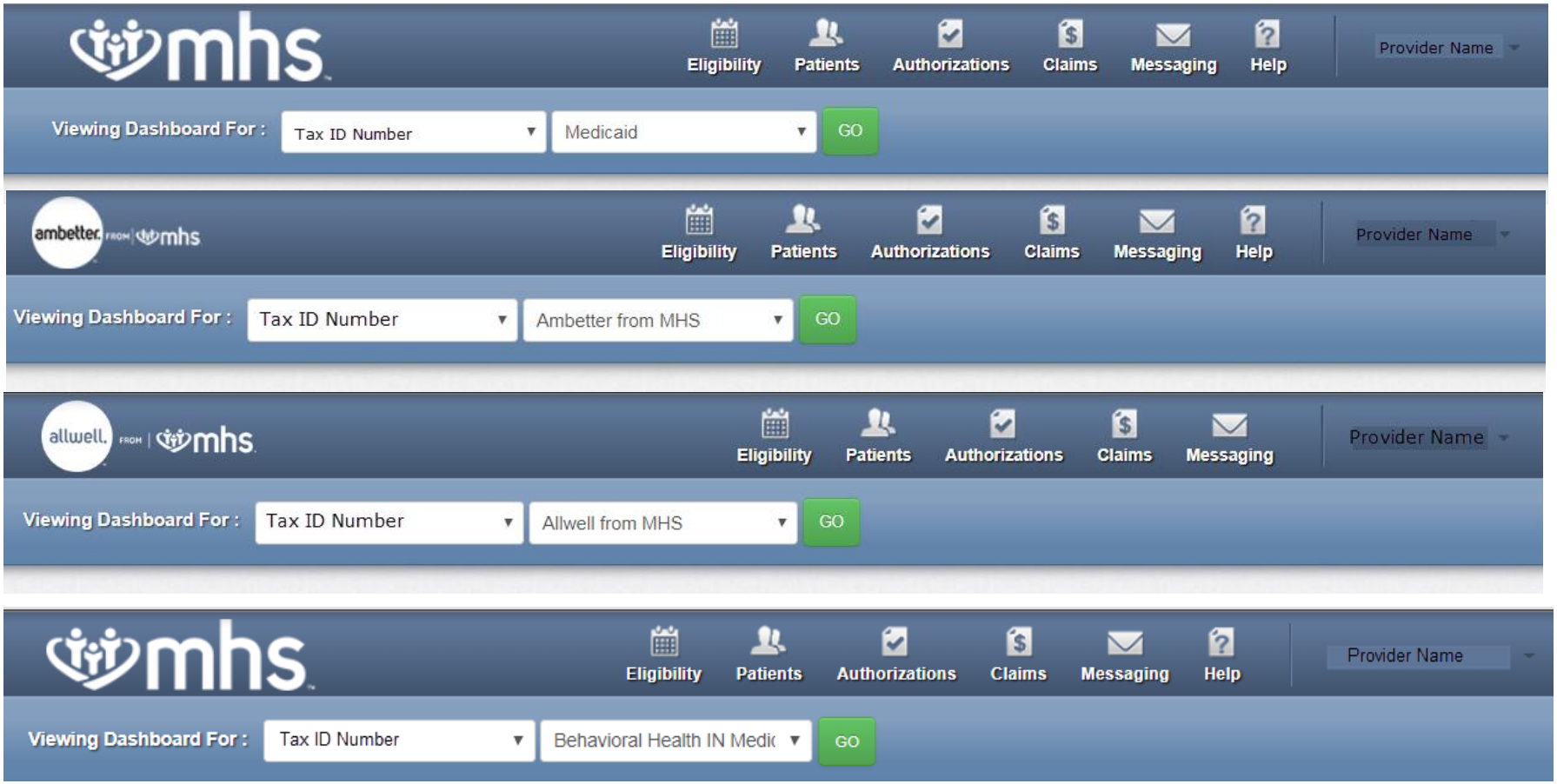






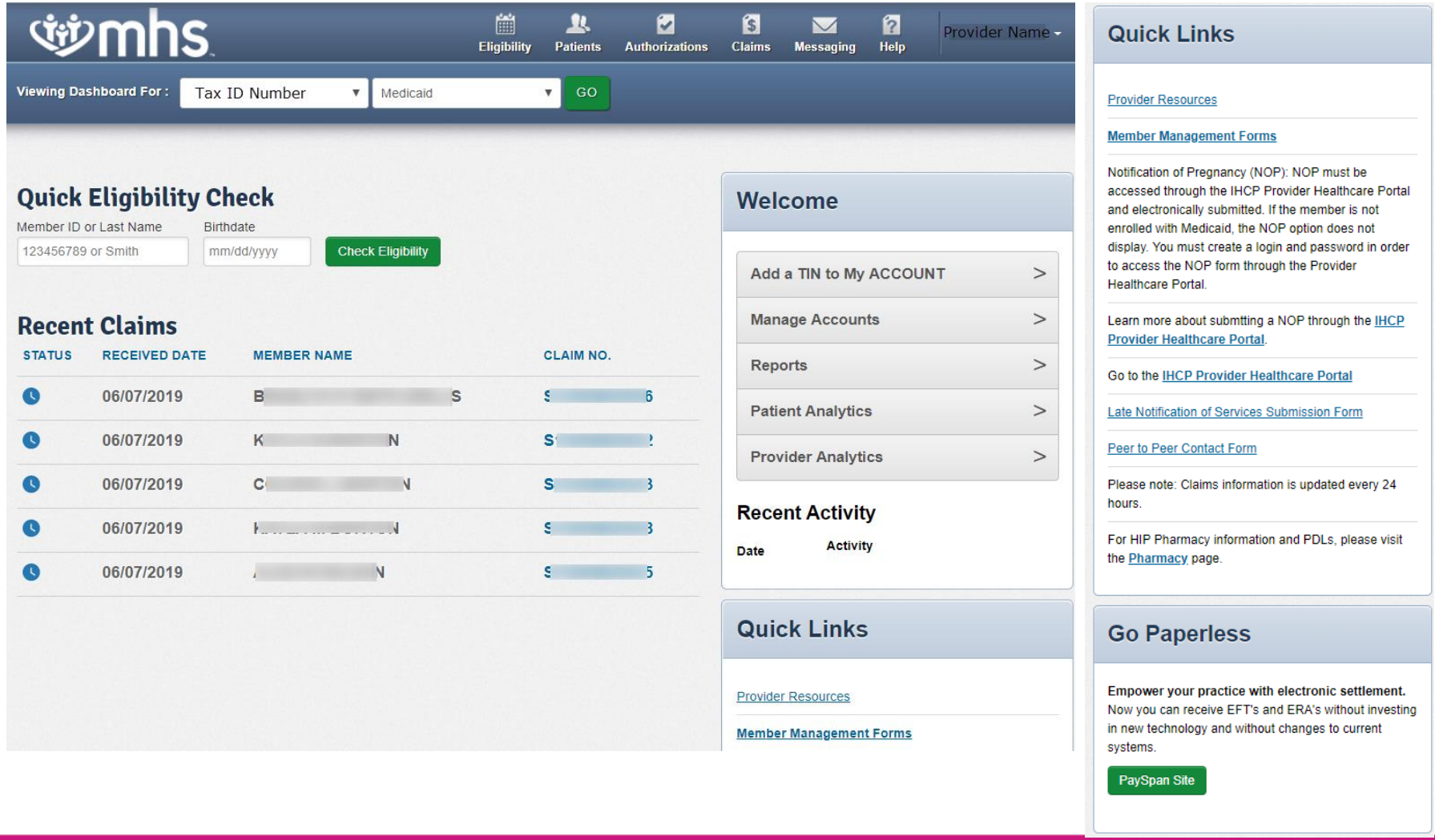
Dashboard Change

- User has the ability to change between **Tax ID Numbers** added along with choices for: **Medicaid**, **Ambetter from MHS, Allwell from MHS** and **Behavioral Health IN Medicaid.**



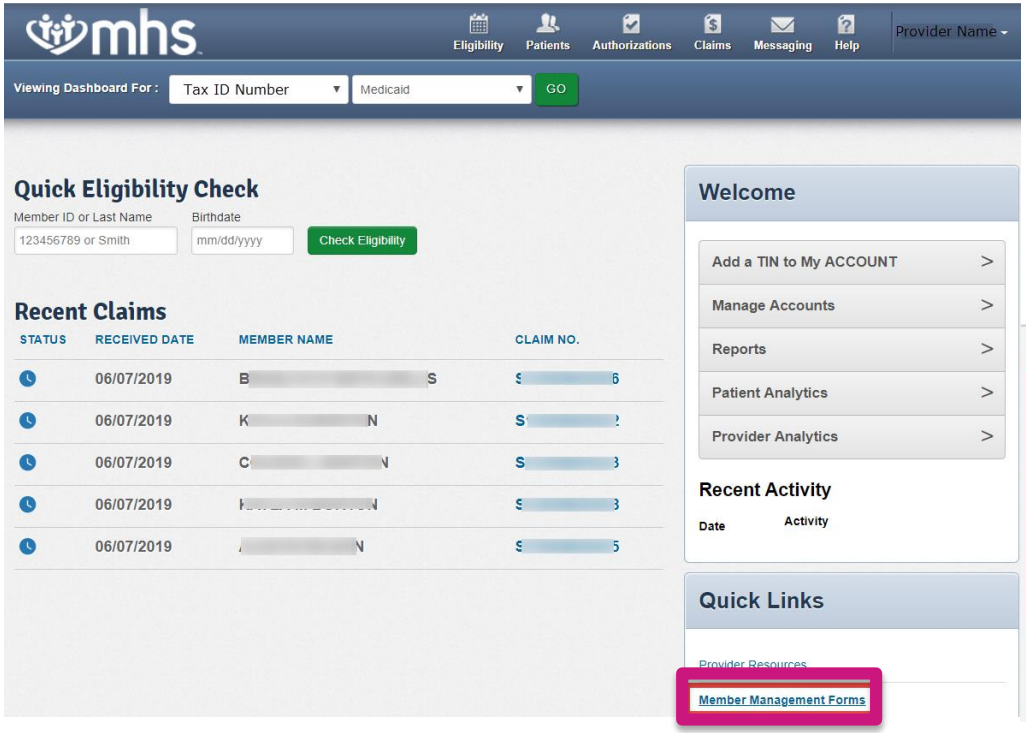
Homepage – MHS (Medicaid)

- Quick Eligibility Check, Recent Claims, Reports, and Quick Links.

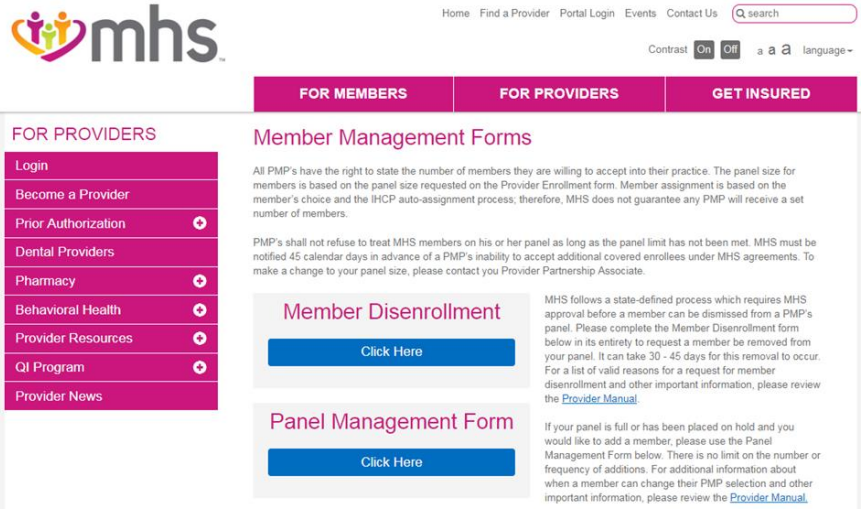


MHS Member Management Forms

Click on **Member Management Forms** under **Quick Links.**



- **Choose between**:
  - Member Disenrollment Form
  - Panel Management Form

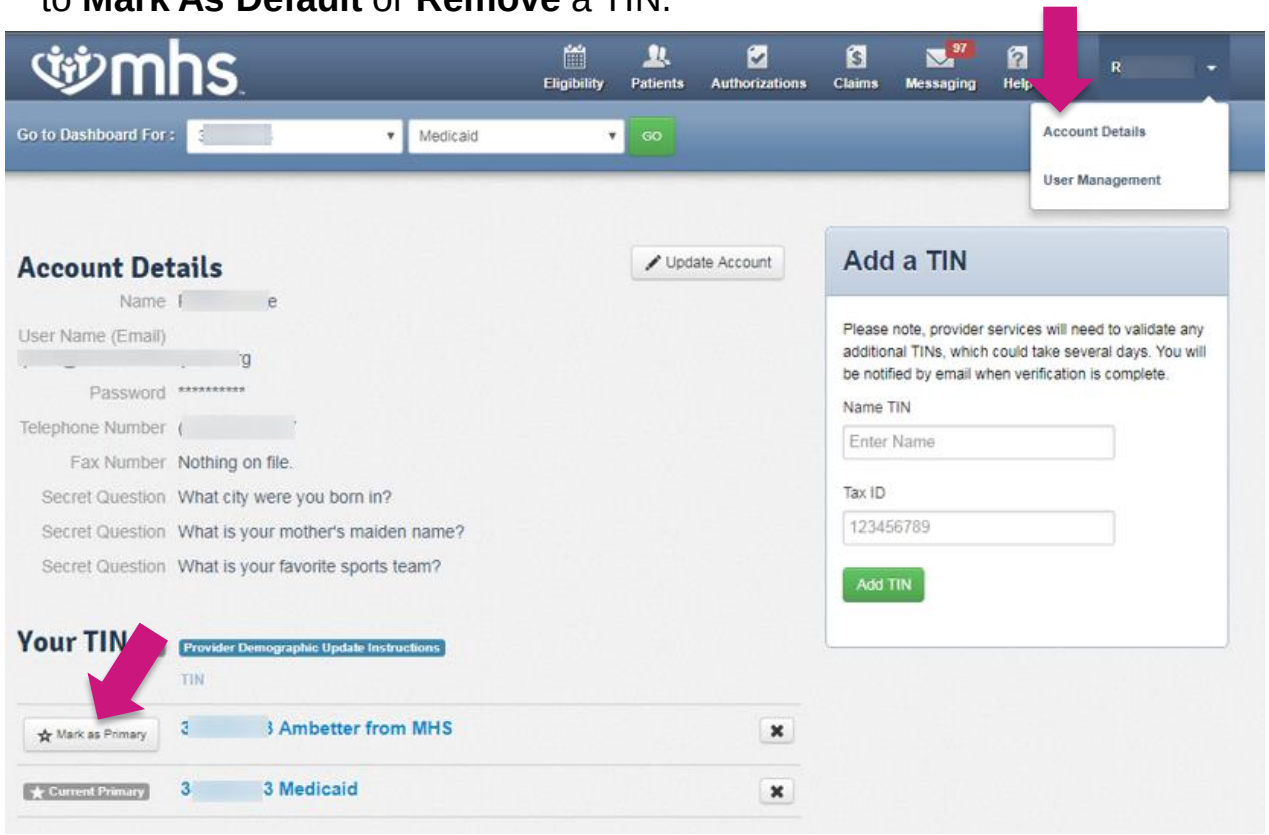


Account Details

To view **Account Details:**

1. Select the **drop-down arrow** next to User Name at the upper right corner on the dashboard
2. Click **Account Details.**

Note: Under Your TINs you see the Current **Primary** Default TIN for the account, and can select another TIN to **Mark As Default** or **Remove** a TIN.



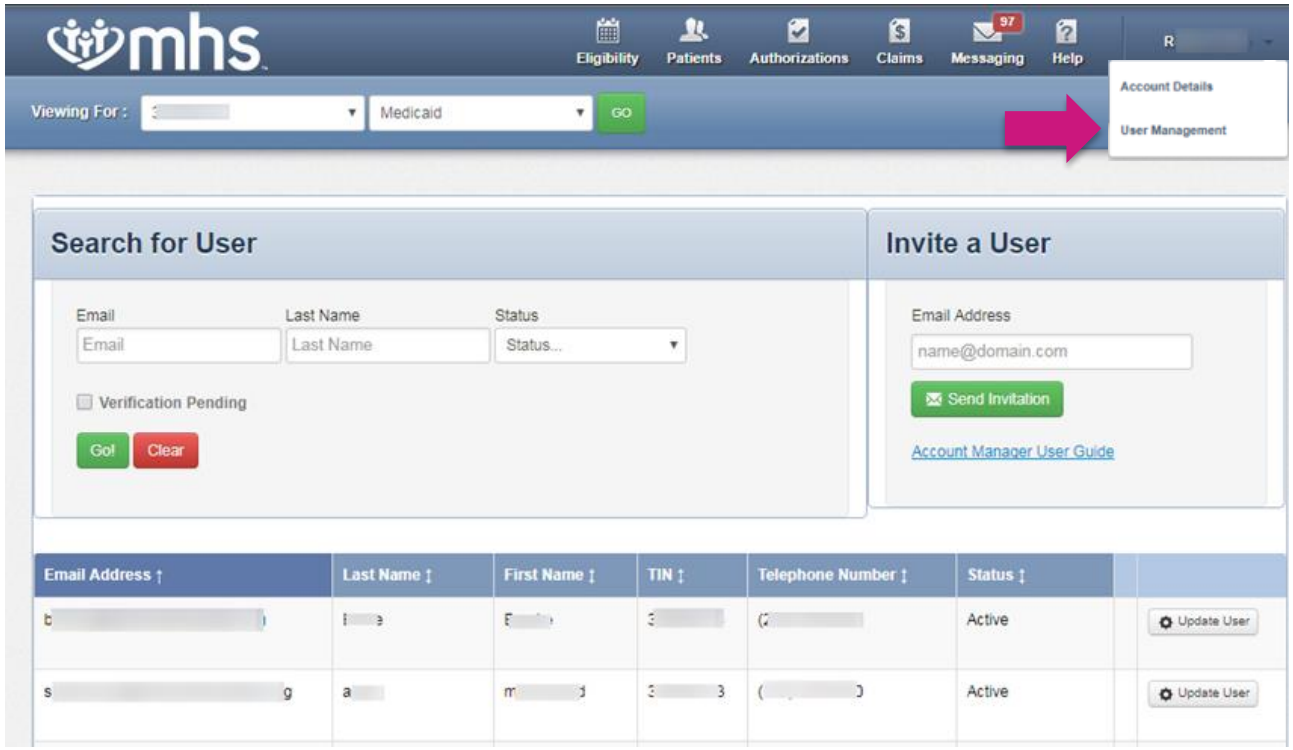
Update Account Details User Guide

Account Manager

User Management

For **Account Managers** to manage their office staff/users associated with their practice: you can disable/enable users, and manage permissions for your account.

1. Select the drop-down arrow next to your name in the upper right corner.
2. Select **User Management**.
3. Click **Update User** next to the user name.

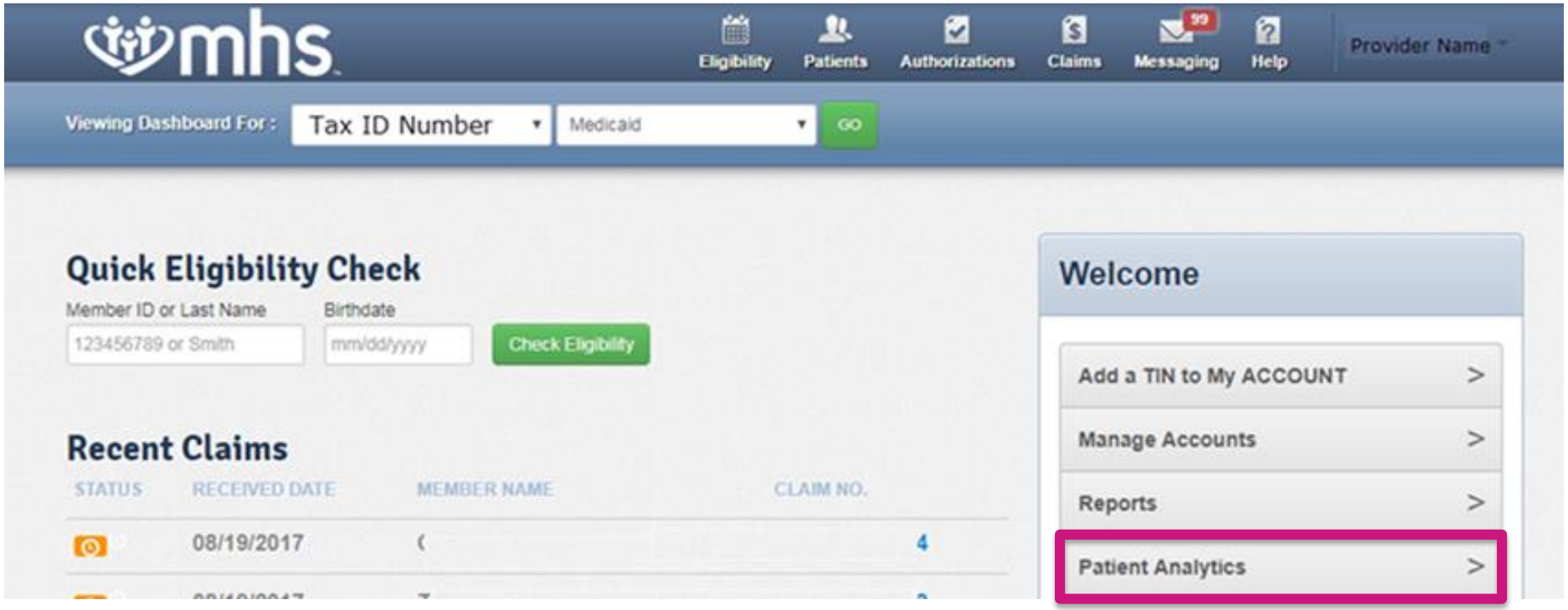


[Account Manager User Guide]

Quality Reports

Patient Analytics

Click on **Patient Analytics** to view reports.



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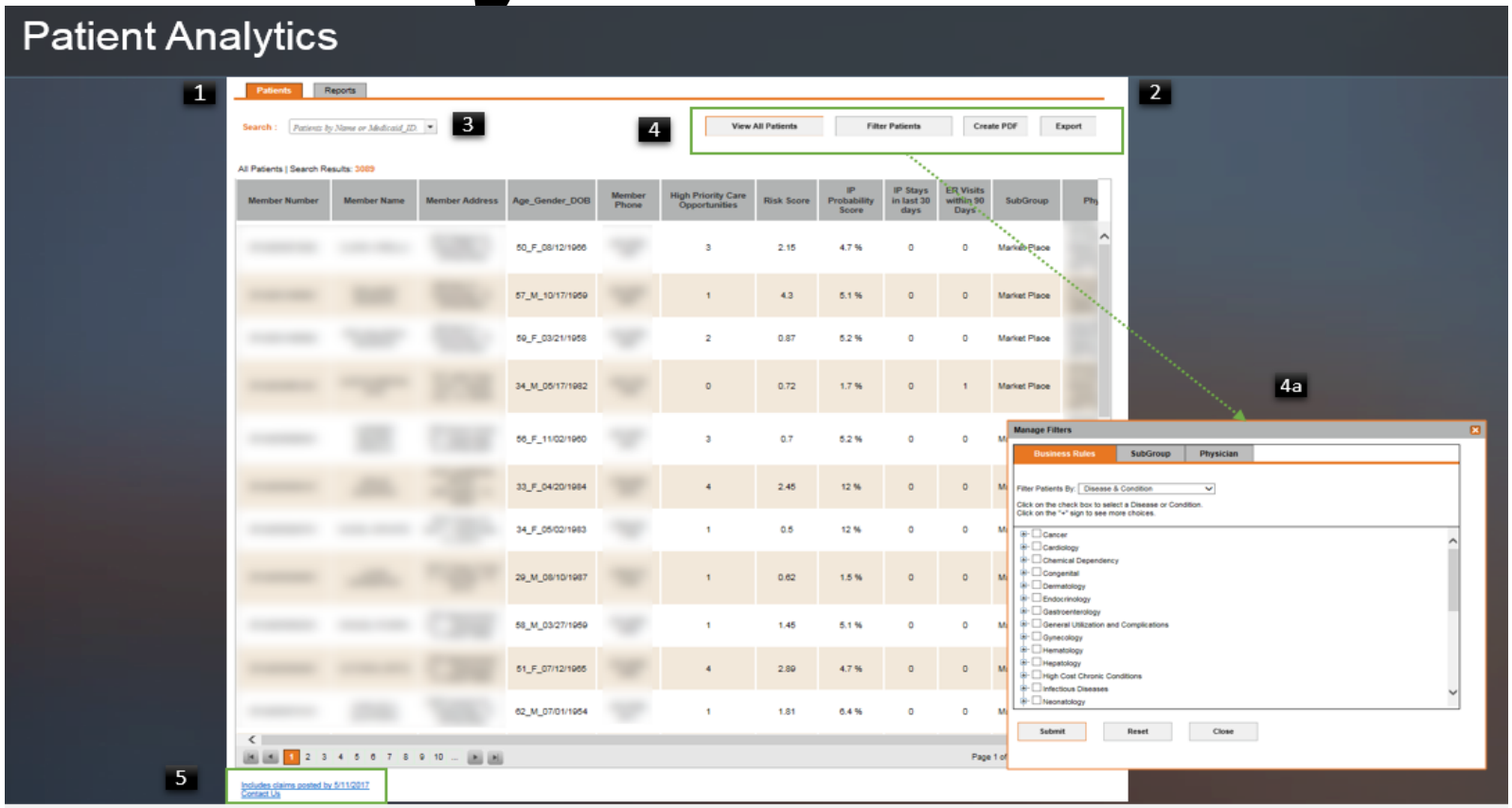
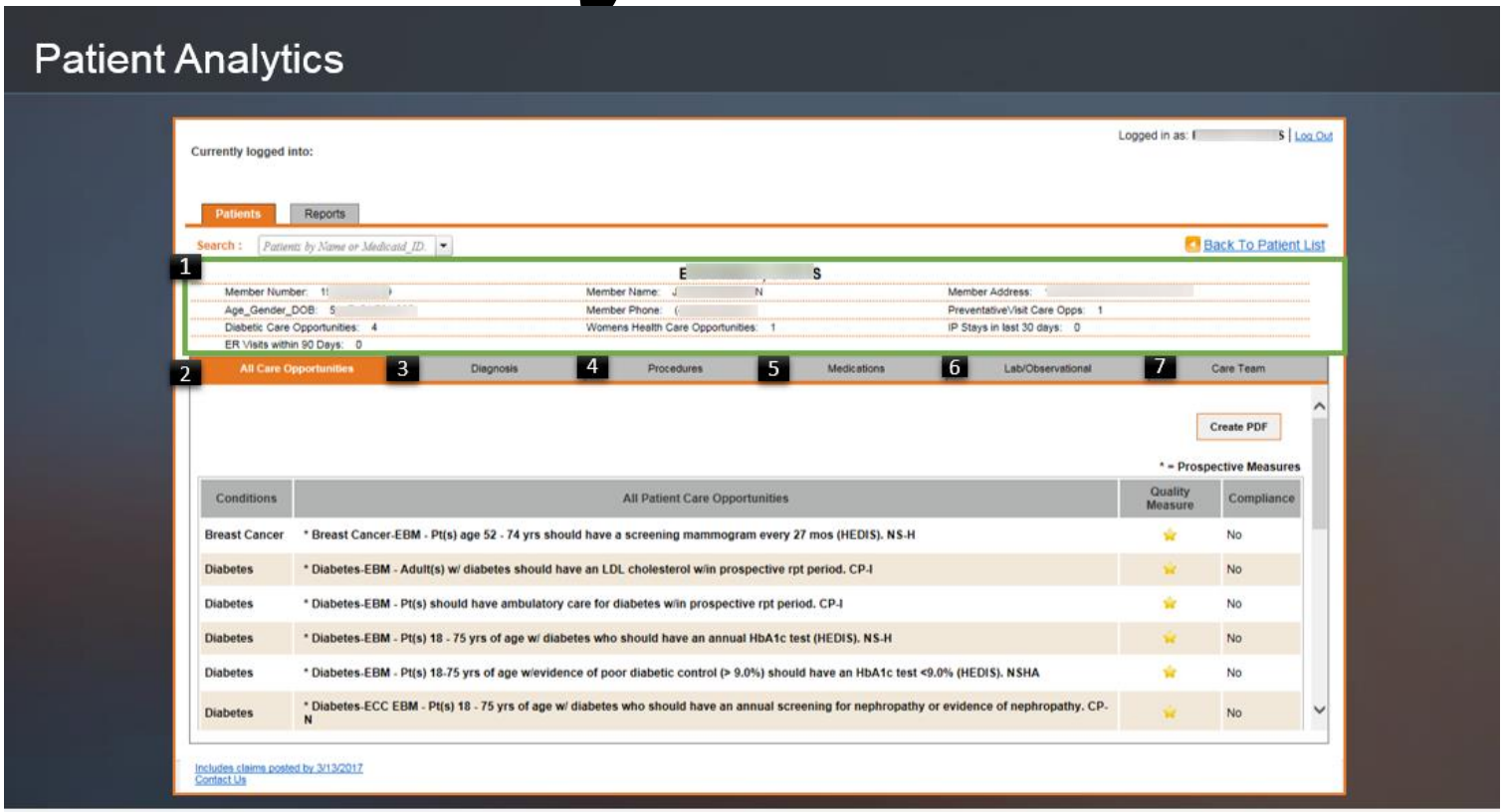


Patients Tab

1. **Tabs:** Allows the providers to choose between the Patients information and Reports.
2. **Logout Button:** For security purposes, logout to protect patient information. Not shown, in upper right hand corner.
3. **Search:** Allows providers to search by the patient's name, Medicaid, Medicare or Marketplace ID number.
4. **Filters and Export Features:** Allows users to view all patients or filter by multiple criteria. The users will also have the ability to create a PDF document or export a detailed patient profile.

   4a. Manage Filters: Filter the patient list by business rules, subgroups, and physicians.
5. **Timeframe:** Provides the date when claims have been posted, followed by a link to contact for questions or concerns.

Patient Analytics

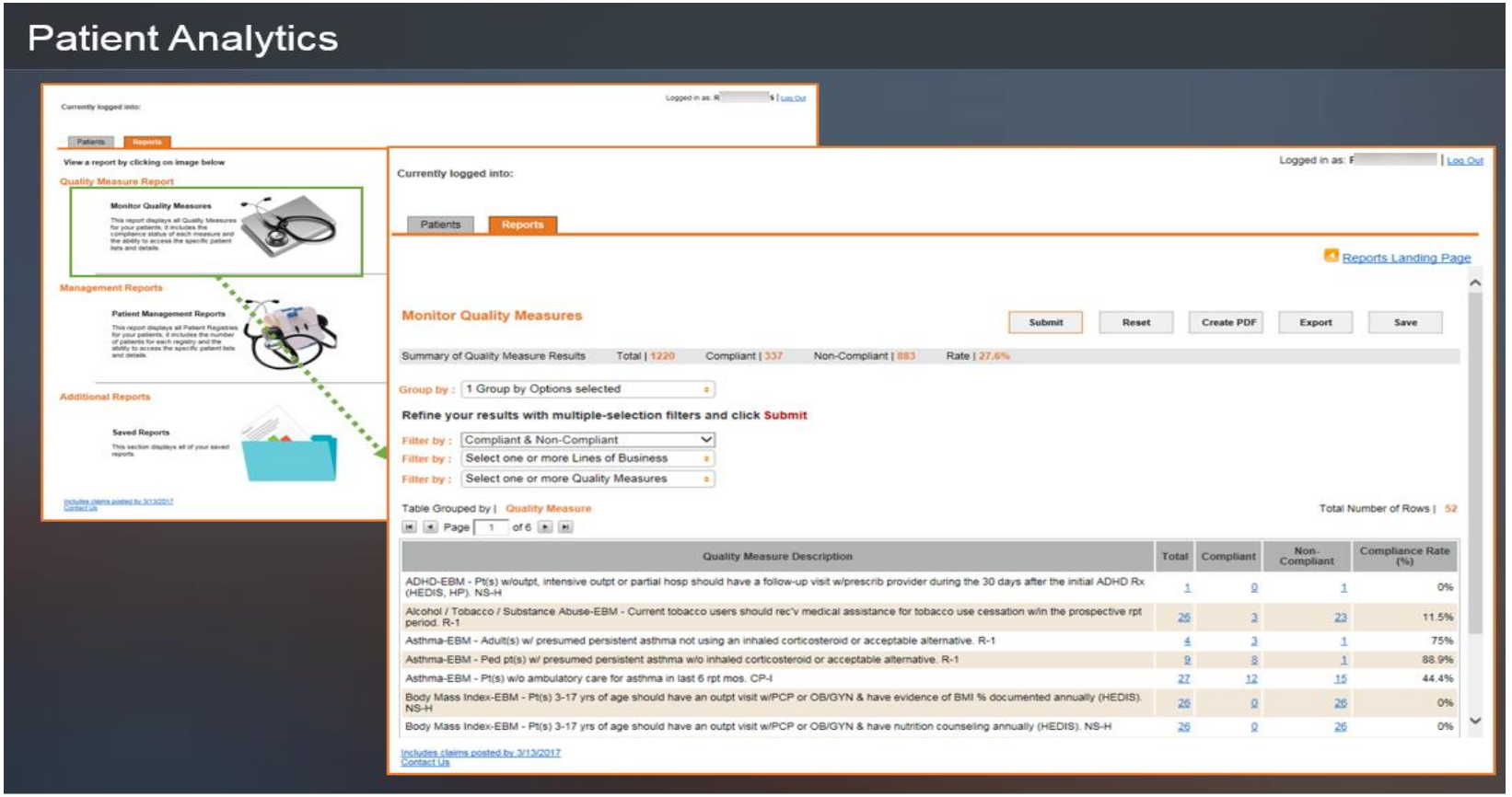


Patient Profile

1. **Member Demographics:** Displays information about the member.
2. **All Care Opportunities:** *The default landing page for patient details.* Displays care opportunities or measures that indicate if a patient has or has not received treatment for a health condition.
3. **Diagnosis:** Shows primary and secondary diagnoses from claims data.
4. **Procedures:** Shows patient procedures associated with primary and secondary diagnoses.
5. **Medications:** Displays a list of medications prescribed to the patient.
6. **Lab/Observational:** Shows lab values, interpretations, and trends.
7. **Care Team:** Allows users to view the patient's providers. Providers are labeled as Managing Doctor or Other Doctor.

Patient Analytics

Quality Measure Report by selected groups and filters.

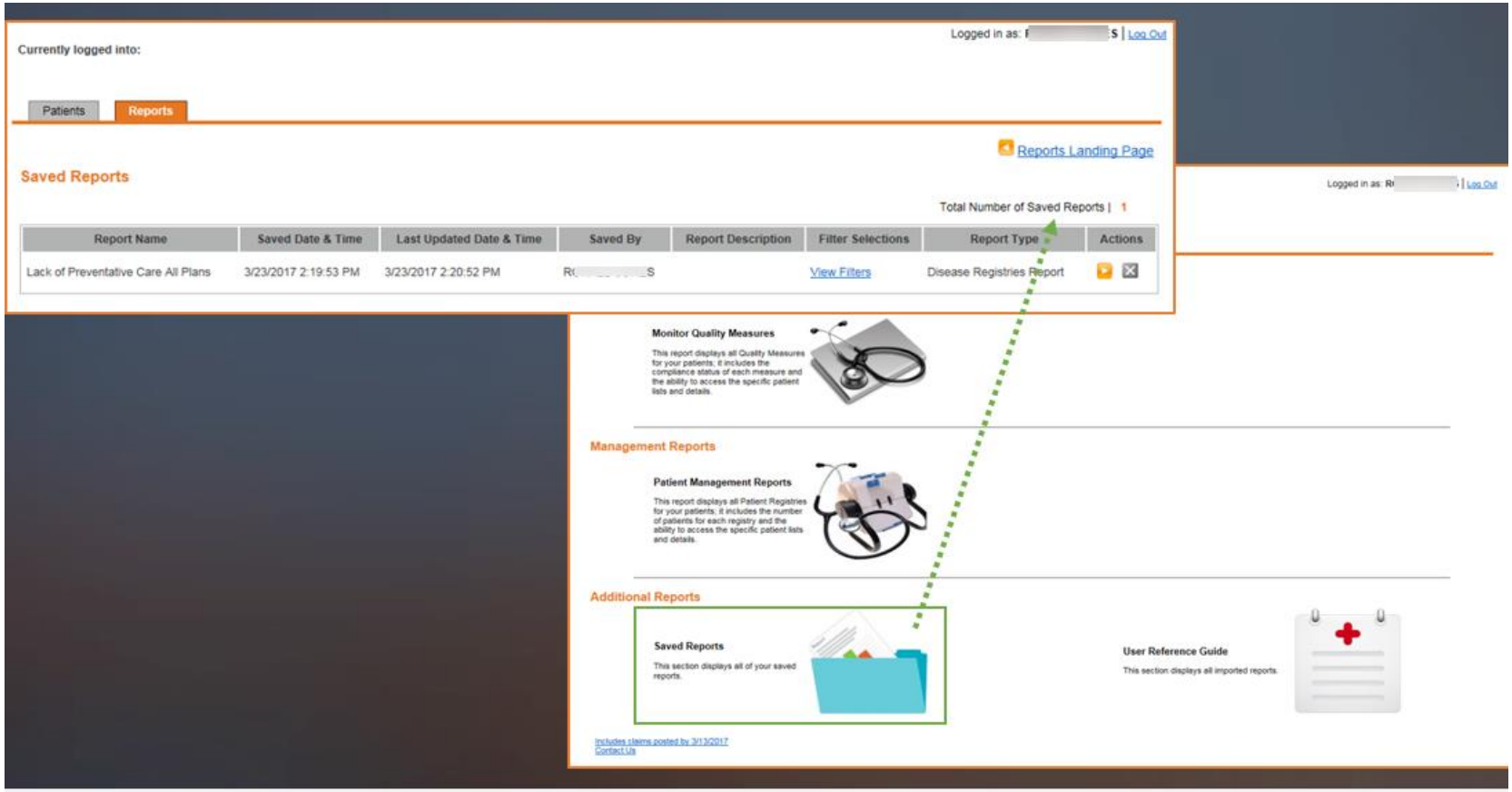


Quality Measure Report:

Monitor Quality Measures Report

- Users are able to view reports by selected grouping and filtering options.

Patient Analytics



Additional Reports

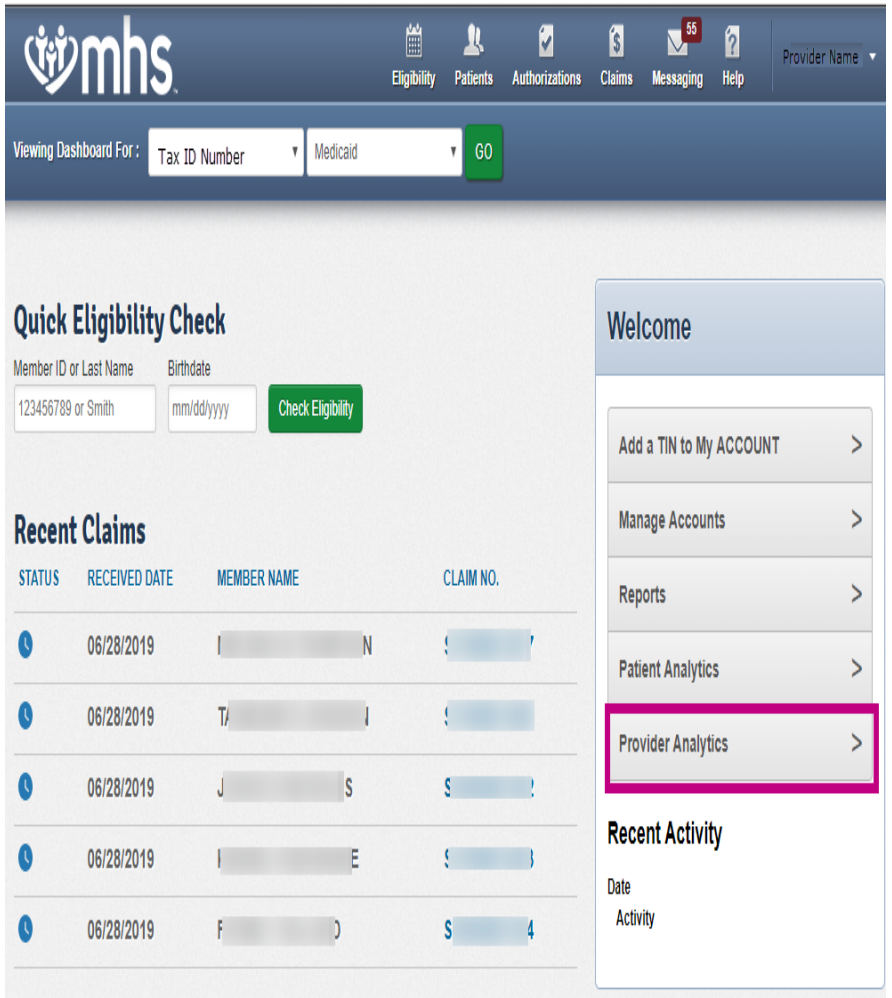
Saved Reports:

- Shows reports saved by current user.

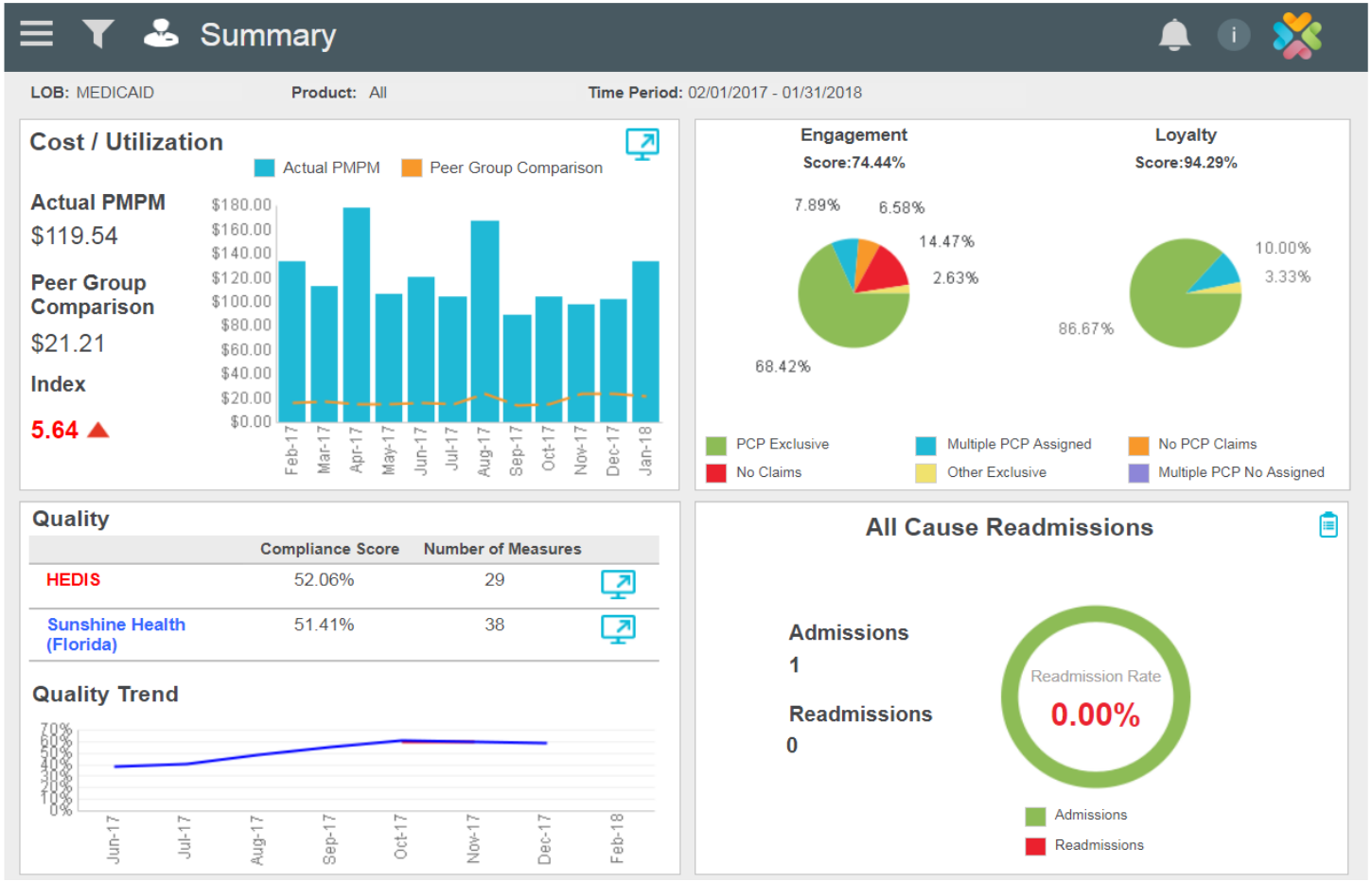
Provider Analytics Overview and Navigation Guide

To navigate **Provider Analytics**:

1. Click on the ***Provider Analytics*** tab to be directed to the landing page.
2. Here you will be able to view four dashboards:
   a. Cost/Utilization
   b. Engagement Analysis
   c. Quality
   d. Readmission by Disease State

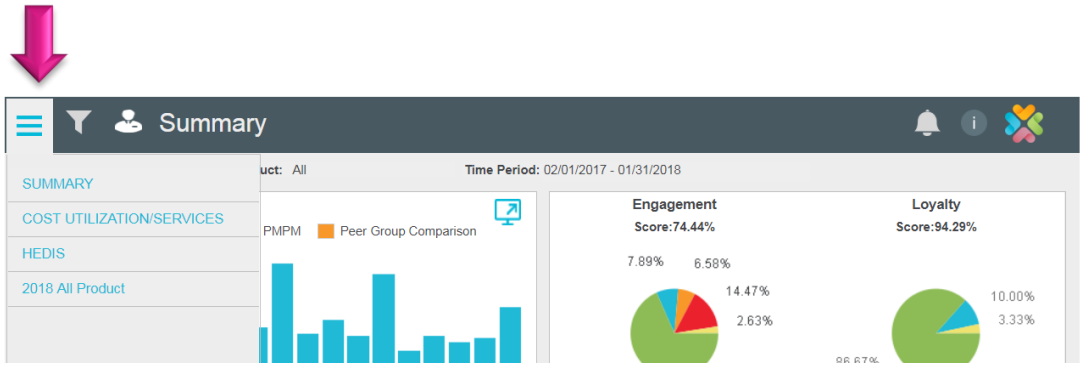


Provider Analytics Navigation Guide



Landing Page Overview

- **Summary Banner:** The dark grey banner contains five icons that will help you navigate the information on the page. You can hover over each icon to view a definition of each icon's purpose.
  - Navigation Bar (three horizontal lines)
  - Funnel – Used to filter data
  - Person – Provider information
  - Bell – Alerts
  - An "i" with a circle – Information
- **Navigation Bar Drop Down:** The following options appear:
  - Summary
  - Cost/Utilization Services
  - Quality
  - Lab
  - Pharmacy
- Case studies have been developed that highlight detailed use cases for each tab.

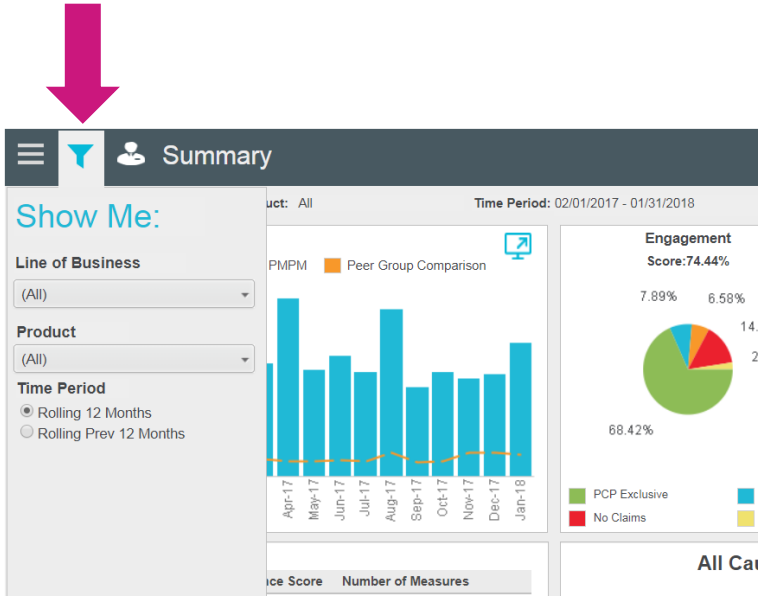


Landing Page Overview

- **Payment History**
  - Added to the drop down bar.
  - PDF Report only.
  - Ensures all providers have access to prior VBC scorecards.
  - Providers in current P4P program have access to PDF copies.
  - Providers no longer participating still have access to prior months.

Landing Page Overview

- **Funnel Icon:** Use this to select an option to view data specific to selected criteria
  - **Line of Business**
    - Commercial
    - Medicaid
    - Medicare
  - **Product**
    - Medicaid
    - Marketplace
    - Medicare
  - **Time Period**
    - Rolling 12 months from current date
    - Previous rolling 12 months
    - Note: There is a 3-month data lag

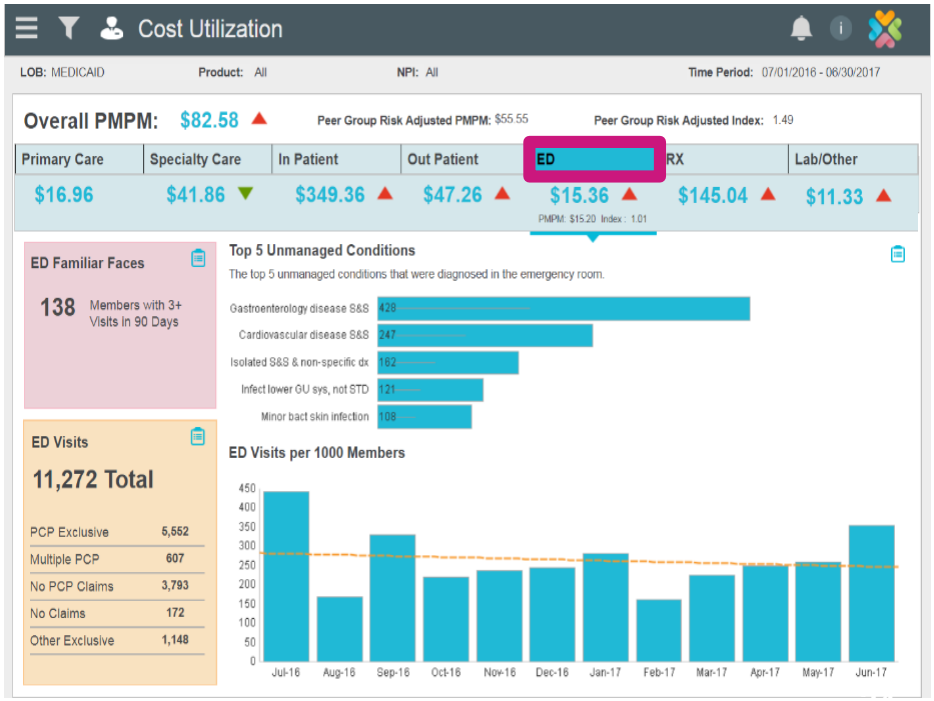


Dashboard View

- **Cost/Utilization:** This dashboard will show your actual Per Member Per Month compared to expected on a monthly basis.
- **Quality:** The Quality dashboard in the lower left quadrant shows HEDIS and Value Based Contract (VLC) performance
- **Engagement Analysis:** This dashboard will show a view of your members' utilization of PMP and healthcare services.
- **Readmission by Disease State:** This dashboard will show total inpatient visits and total readmits. It will show the number of total readmits and those without PMP follow-up and follow-up rate.
- The Cost/Utilization and Quality sections have dashboards providing more specific data down to the member level. To view this data, click on the **blue computer monitor icons.**

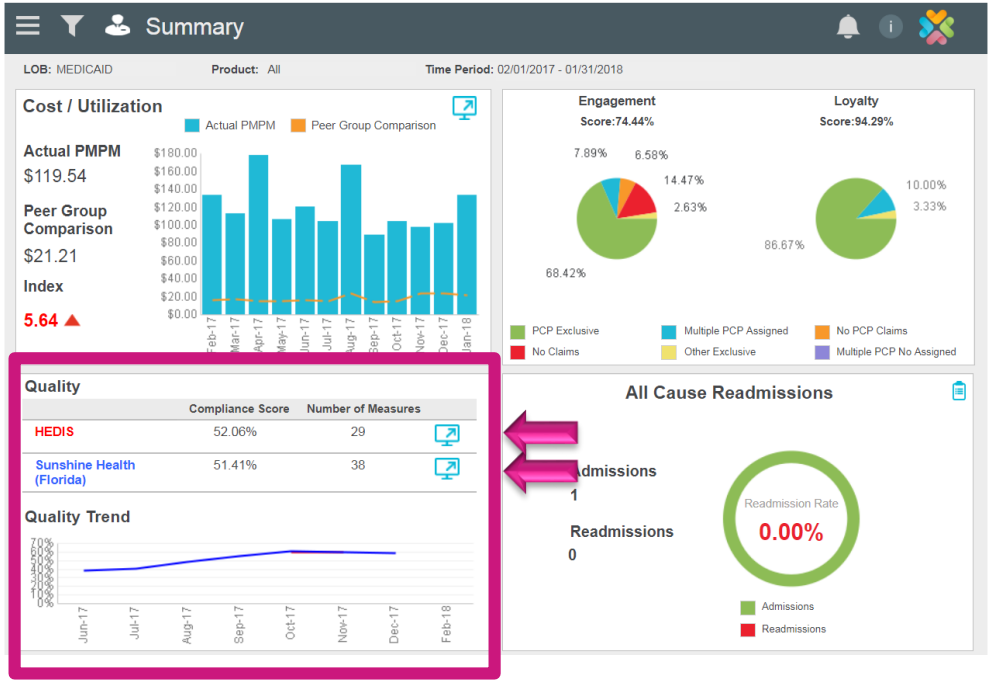
Cost & Utilization: ED

- Shows PMPM for ED visits compared to peers' risk-adjusted PMPM.
- Four sections:
  - Bar graph shows top five unmanaged conditions
  - Bottom of the page shows average ED visits for provider's patients compared to plan.
  - Box on top left side shows number of patients with 3+ visits in the last 90 days.
  - Box on bottom left side shows number of total ED visits by engagement category.
- Click on the charts for patient-level detail.



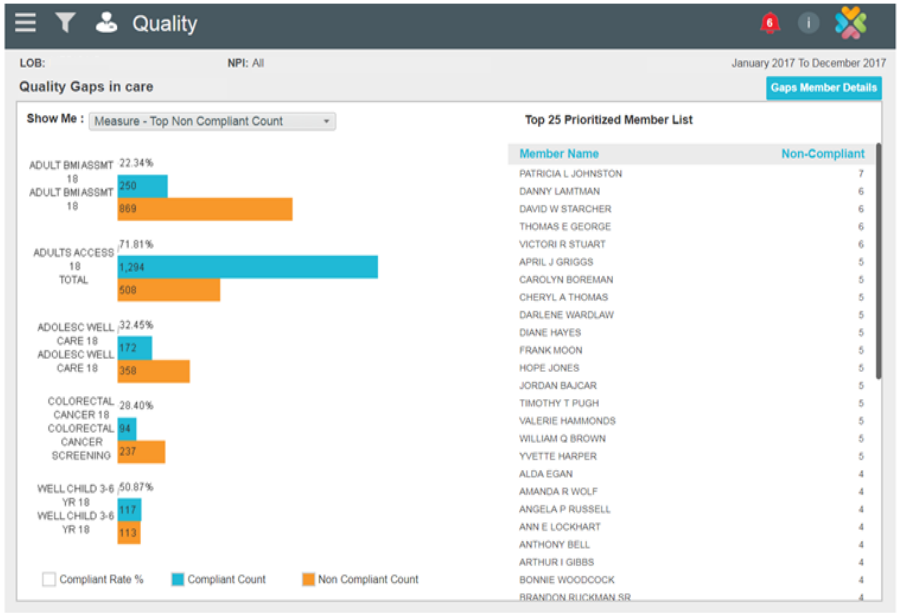
Quality HEDIS View

- Shows trends in closing HEDIS care gaps and earnings from any Pay for Performance(P4P) programs.
- Click the blue screen next to HEDIS to view performance in 100+ care gaps and export member-level reports.
- Click the blue screen next to VBC PPM to see earnings from P4P program, amount outstanding and amount left to earn per measure.



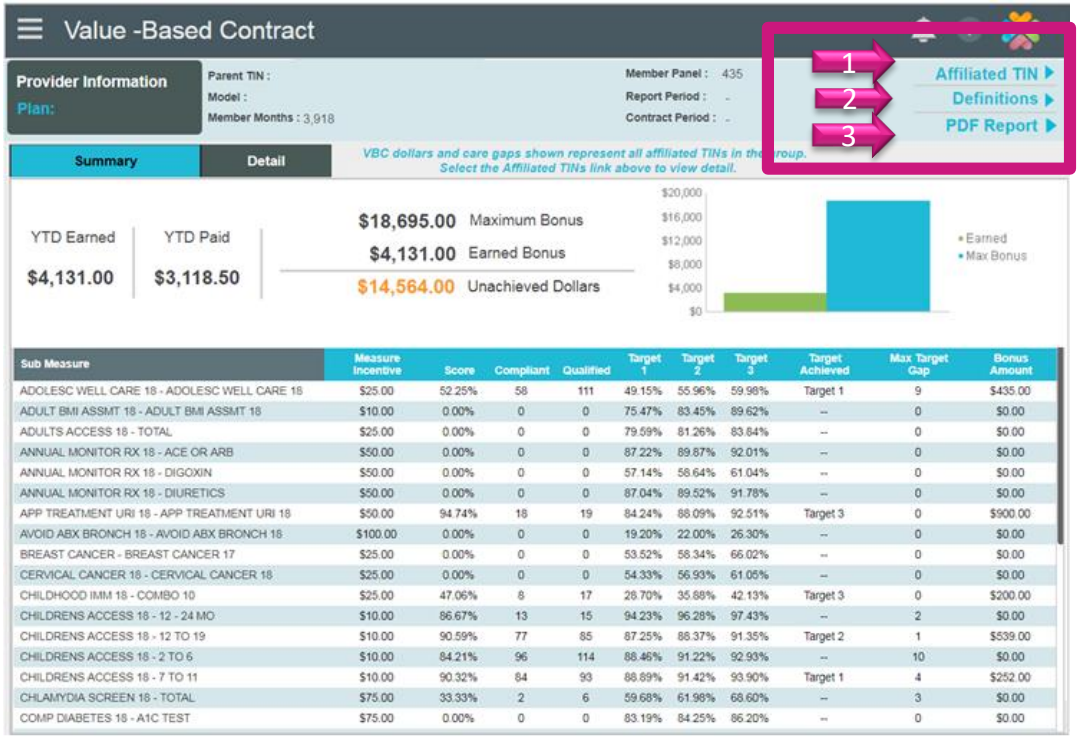
Quality HEDIS View: Gaps in Care

- Left defaults to top five measures by non-compliant count.
- Drop-down arrow changes view to see:
  - Measures – Non-compliant count, compliant count, compliant rate % or all.
  - NPI – Non-compliant count, compliant count, compliant rate % or all.
- Right side displays top 25 members with the most open care gaps.



Quality HEDIS View

- For providers in P4P arrangement.
- Value-Base Contract: Shows measure incentive, amount earned, and unachieved dollars.
- In right hand corner:
  1. All TINs associated with P4P program.
  2. List of definitions and meanings.
  3. Scorecard summarizing provider's performance in Quality.

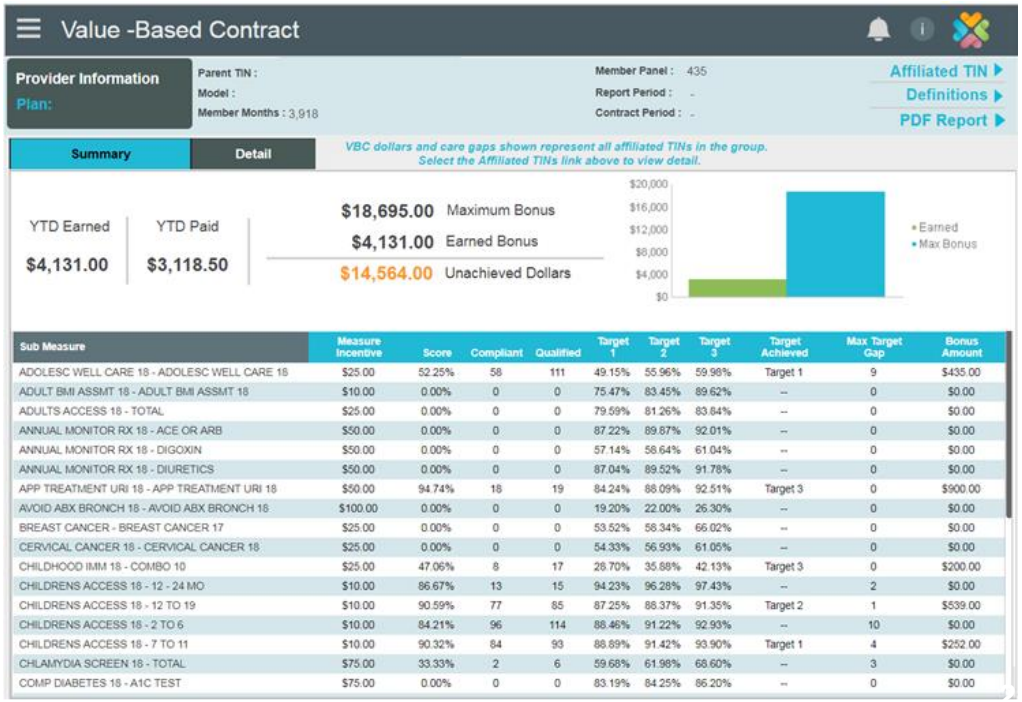


Sub Measure	Measure Incentive	Score	Compliant	Qualified	Target 1	Target 2	Target 3	Target Achieved	Max Target Gap	Bonus Amount
ADOLESC WELL CARE 18 - ADOLESC WELL CARE 18	$25.00	52.25%	58	111	49.15%	55.96%	59.98%	Target 1	9	$435.00
ADULT BMI ASSMT 18 - ADULT BMI ASSMT 18	$10.00	0.00%	0	0	75.47%	83.45%	89.62%	--	0	$0.00
ADULTS ACCESS 18 - TOTAL	$25.00	0.00%	0	0	79.59%	81.26%	83.84%	--	0	$0.00
ANNUAL MONITOR RX 18 - ACE OR ARB	$50.00	0.00%	0	0	87.22%	89.87%	92.01%	--	0	$0.00
ANNUAL MONITOR RX 18 - DIGOXIN	$50.00	0.00%	0	0	57.14%	58.64%	61.04%	--	0	$0.00
ANNUAL MONITOR RX 18 - DIURETICS	$50.00	0.00%	0	0	87.04%	89.52%	91.78%	--	0	$0.00
APP TREATMENT URI 18 - APP TREATMENT URI 18	$50.00	94.74%	18	19	84.24%	88.09%	92.51%	Target 3	0	$900.00
AVOID ABX BRONCH 18 - AVOID ABX BRONCH 18	$100.00	0.00%	0	0	19.20%	22.00%	26.30%	--	0	$0.00
BREAST CANCER - BREAST CANCER 17	$25.00	0.00%	0	0	53.52%	58.34%	66.02%	--	0	$0.00
CERVICAL CANCER 18 - CERVICAL CANCER 18	$25.00	0.00%	0	0	54.33%	56.93%	61.05%	--	0	$0.00
CHILDHOOD IMM 18 - COMBO 10	$25.00	47.06%	8	17	28.70%	35.68%	42.13%	Target 3	0	$200.00
CHILDRENS ACCESS 18 - 12 - 24 MO	$10.00	86.67%	13	15	94.23%	96.28%	97.43%	--	2	$0.00
CHILDRENS ACCESS 18 - 12 TO 19	$10.00	90.59%	77	85	87.25%	88.37%	91.35%	Target 2	1	$539.00
CHILDRENS ACCESS 18 - 2 TO 6	$10.00	84.21%	96	114	88.46%	91.22%	92.93%	--	10	$0.00
CHILDRENS ACCESS 18 - 7 TO 11	$10.00	90.32%	84	93	88.89%	91.42%	93.90%	Target 1	4	$252.00
CHLAMYDIA SCREEN 18 - TOTAL	$75.00	33.33%	2	6	59.68%	61.98%	66.60%	--	3	$0.00
COMP DIABETES 18 - A1C TEST	$75.00	0.00%	0	0	83.19%	84.25%	86.20%	--	0	$0.00

Quality HEDIS View

You can also view:

- Compliant Score
- Compliant and Qualified number per Sub Measure
- Target levels for compliant percentage needed to earn a payout
- Target level achieved
- Number of gaps needed to close to reach Maximum Target Level
- Bonus Amount earned



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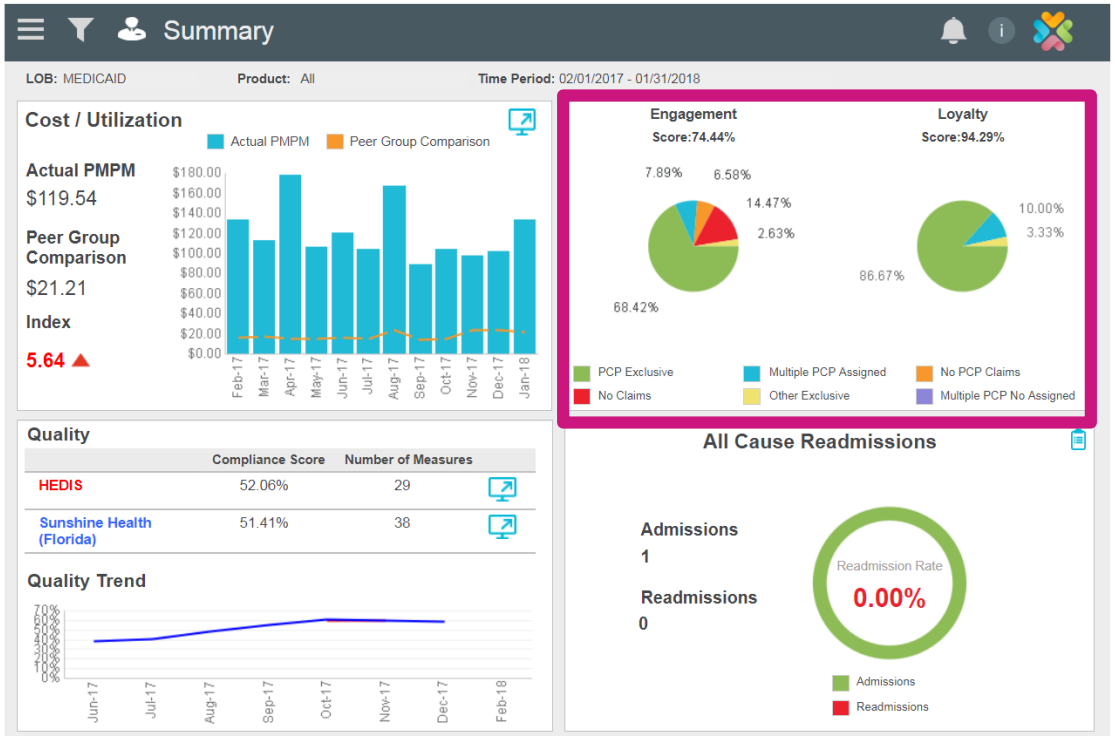
Engagement & Loyalty Analysis

Classifies member interactions with Primary Medical Physician (PMP) services into two main categories:

- **Provider Engagement:** Measures provider's efficiency with engaging assigned members to be seen for a primary care visit annually; **includes all assigned members.**

- **Provider Loyalty:** Measures the provider's ongoing effort to maintain exclusivity as the PMP for assigned panel once members have PMP activity; **excludes assigned members without any PCP visits.**



Engagement & Loyalty Analysis

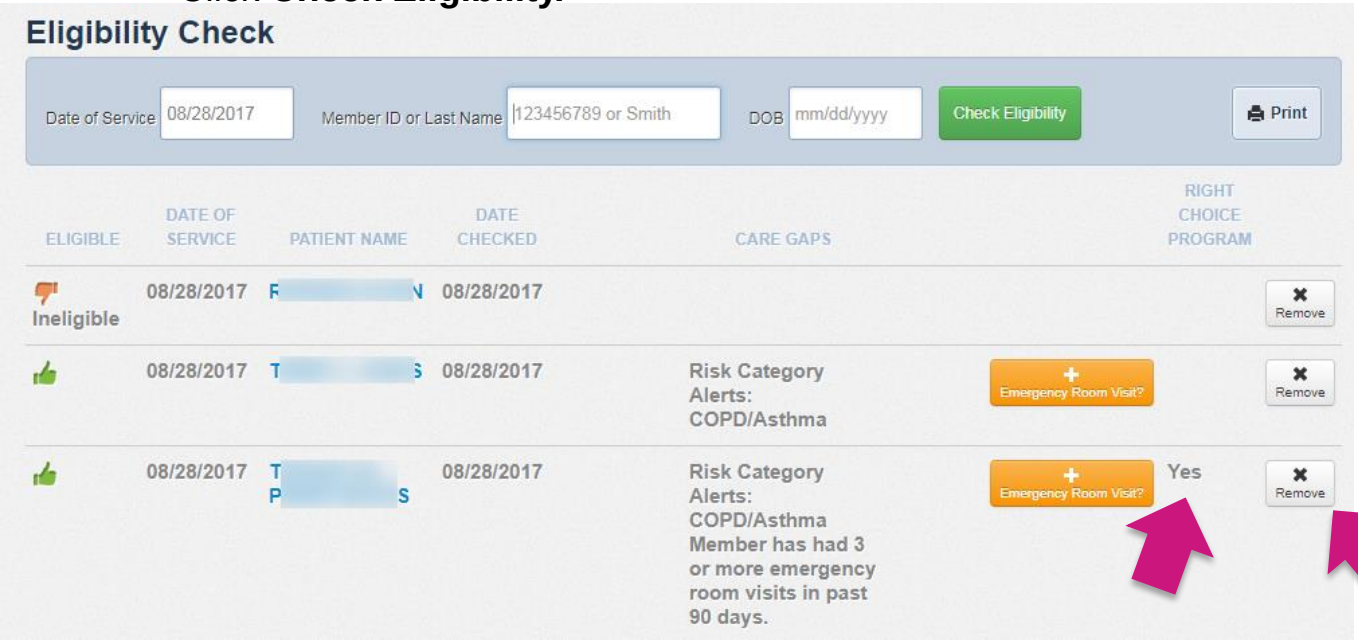
- Provider Engagement is broken into six sub-categories to help identify patient activity and prioritize for outreach.

Patient Segment	Segment Traits	Engagement Strategy
PCP Exclusive	These patients have been assigned to you and have been seen by you or one of your partners.	Identify which of these members have care gaps and close at their next appointment.
Multiple PCP Assigned	These patients are assigned to you, but have been seen by your practice ***AND*** other PCP groups.	Initiate a patient outreach plan, set an appointment if appropriate, close care gaps, discuss benefits of PCP loyalty.
No PCP Claims	These are patients who seek all of their care from specialists, ER, and Urgent Care.	Outreach and set an appointment for a PCP visit, identify health risks and set follow-up appointments, discuss benefits of loyalty.
Other Exclusive	These patients are assigned to you, but have been seeing another PCP group exclusively.	Outreach to members to discuss updating their assigned PCP to the doctor they have been seeing for care.
No Claims	These patients are assigned to you but have no claim data to indicate they have received any medical care from a PCP, emergency department or urgent care center.	Outreach and set an appointment for PCP visit. Identify health risks and set follow-up appointments, discuss benefits of loyalty.
Multiple PCP No Assigned	These patients are assigned to you, but have only been seen other PCP groups.	Outreach to members to discuss benefits of loyalty and promote hours and availability, identify members with care gaps and set appointment for PCP visit.

Member Eligibility and Overview

Check Member Eligibility

- The **Eligibility** tab offers an **Eligibility Check** tool designed to quickly check the status of any member.
  - Update the **Date of Service,** if necessary.
  - Enter the **Member ID** or **Last Name** and **DOB (Date of Birth).**
  - Click **Check Eligibility.**



- Eligibility status is indicated by a Green Thumbs-Up for **Eligible** and an Orange Thumbs-Down for **Ineligible**.

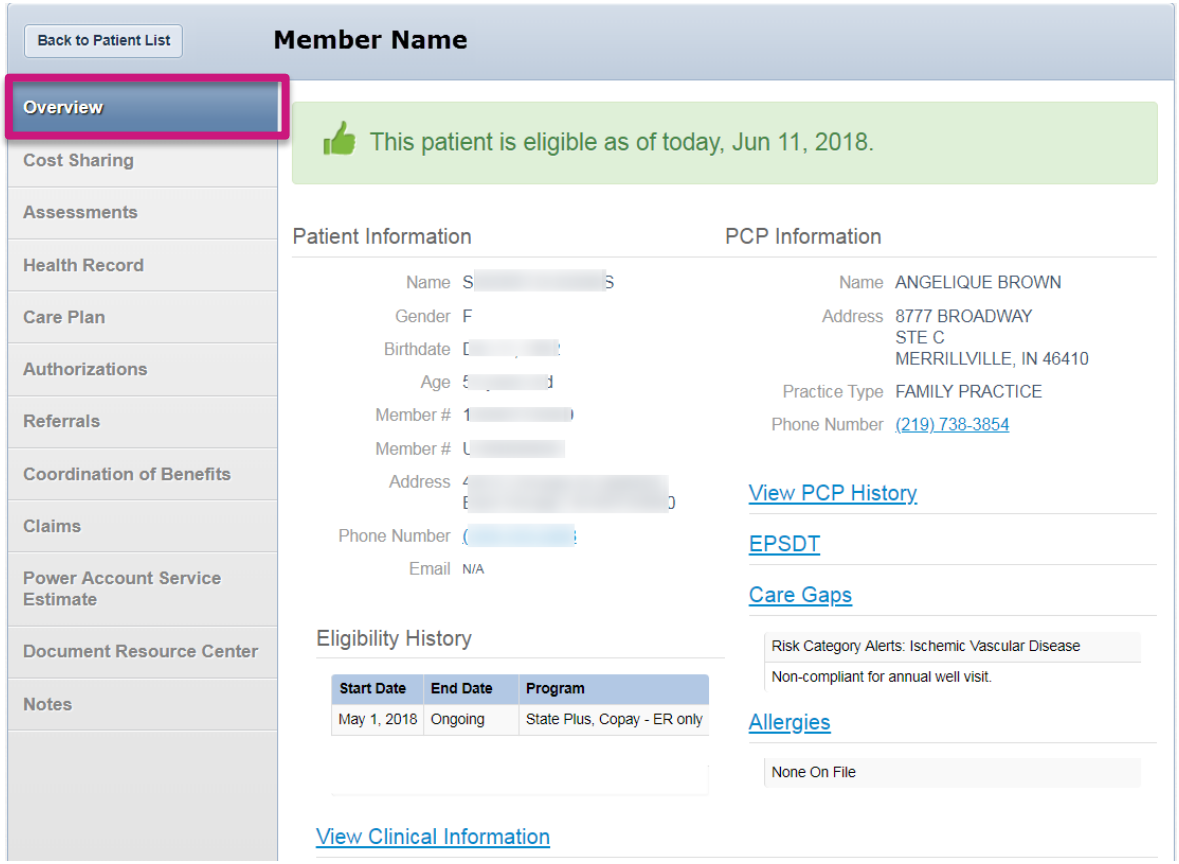
Details for any member can be viewed by clicking on the **Member's Name**.

Care Gaps can also be seen within the search results.

By clicking **Emergency Room Visit?**, an ER visit will be indicated.

Right Choice Program indicator labeled **Yes.**

MHS Member Overview

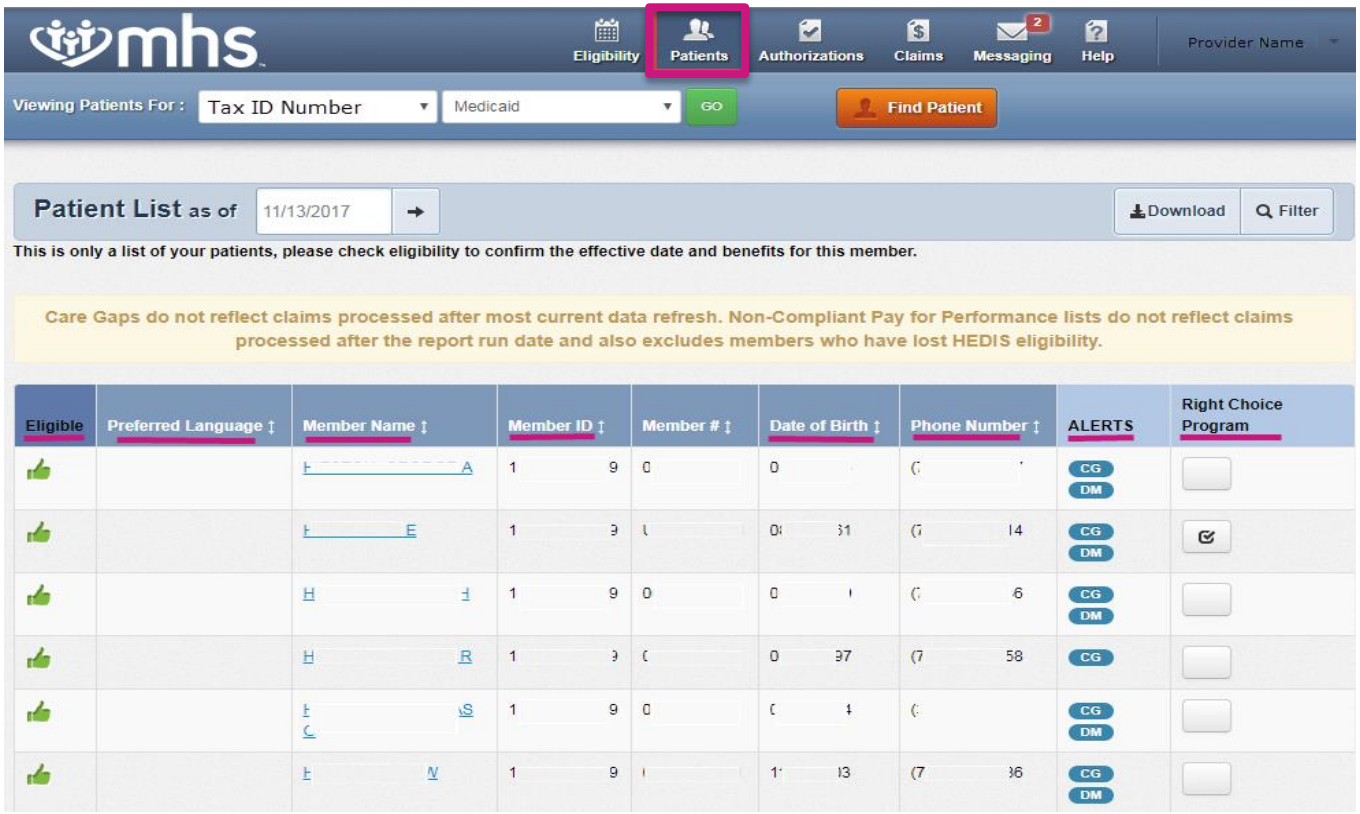


Overview Tab

1. Patient Information
2. Eligibility History
3. PCP Information and PCP History
4. Early and Periodic Screening, Diagnostic and Treatment (**EPSDT**)
5. Care Gaps
6. Allergies

View Patient List

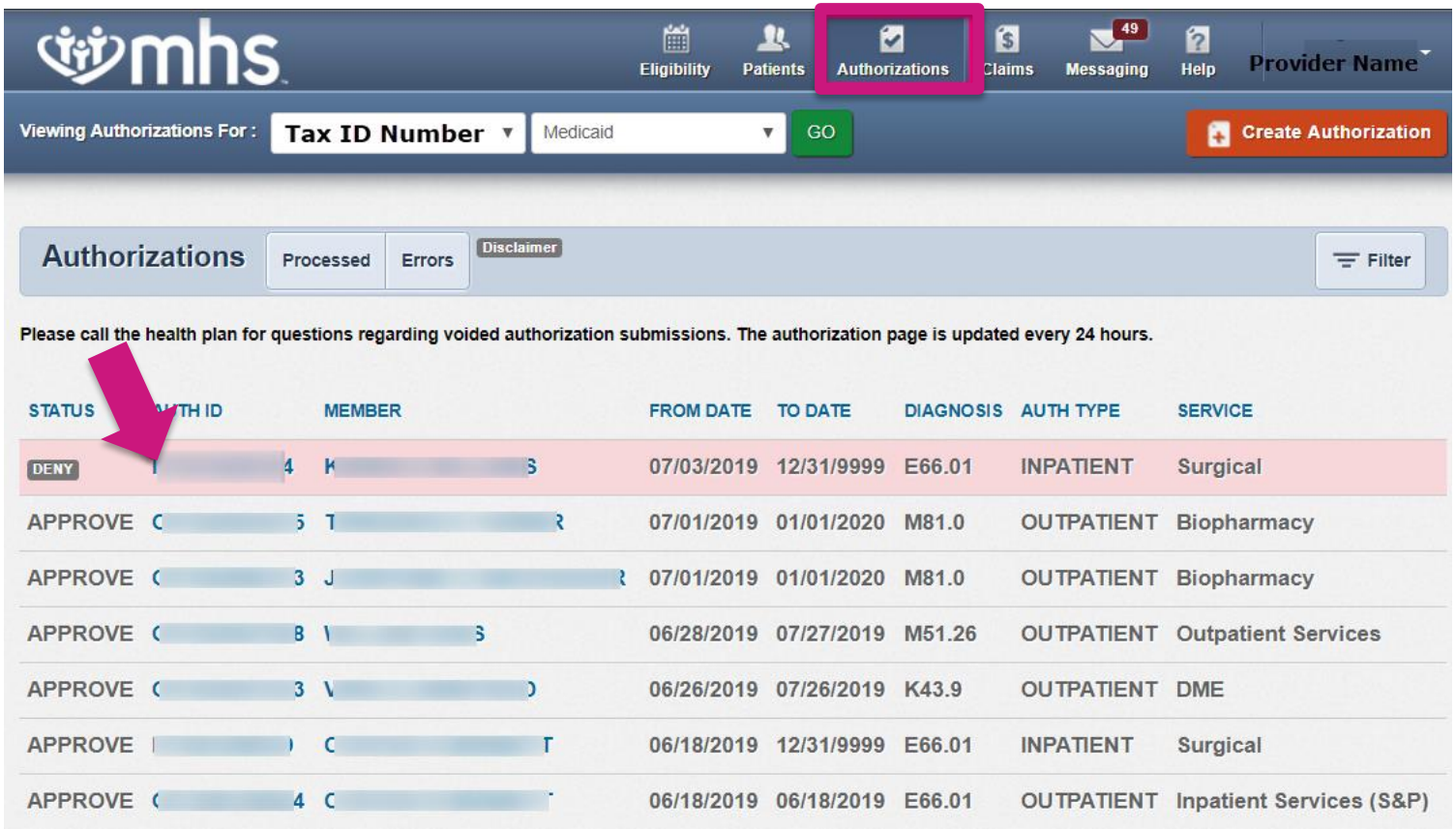
- Click **Patients** tab at the top of the screen.
- The Patient List appears displaying **Eligibility Status**, **Preferred Language**, **Member Name**, **Medicaid ID**, **DOB**, **Phone Number**, **Alerts** and **Right Choice Program**.
- To download the patient list to Excel, click **Download**. This allows for you to manage your patient information as desired in Excel.



Authorizations

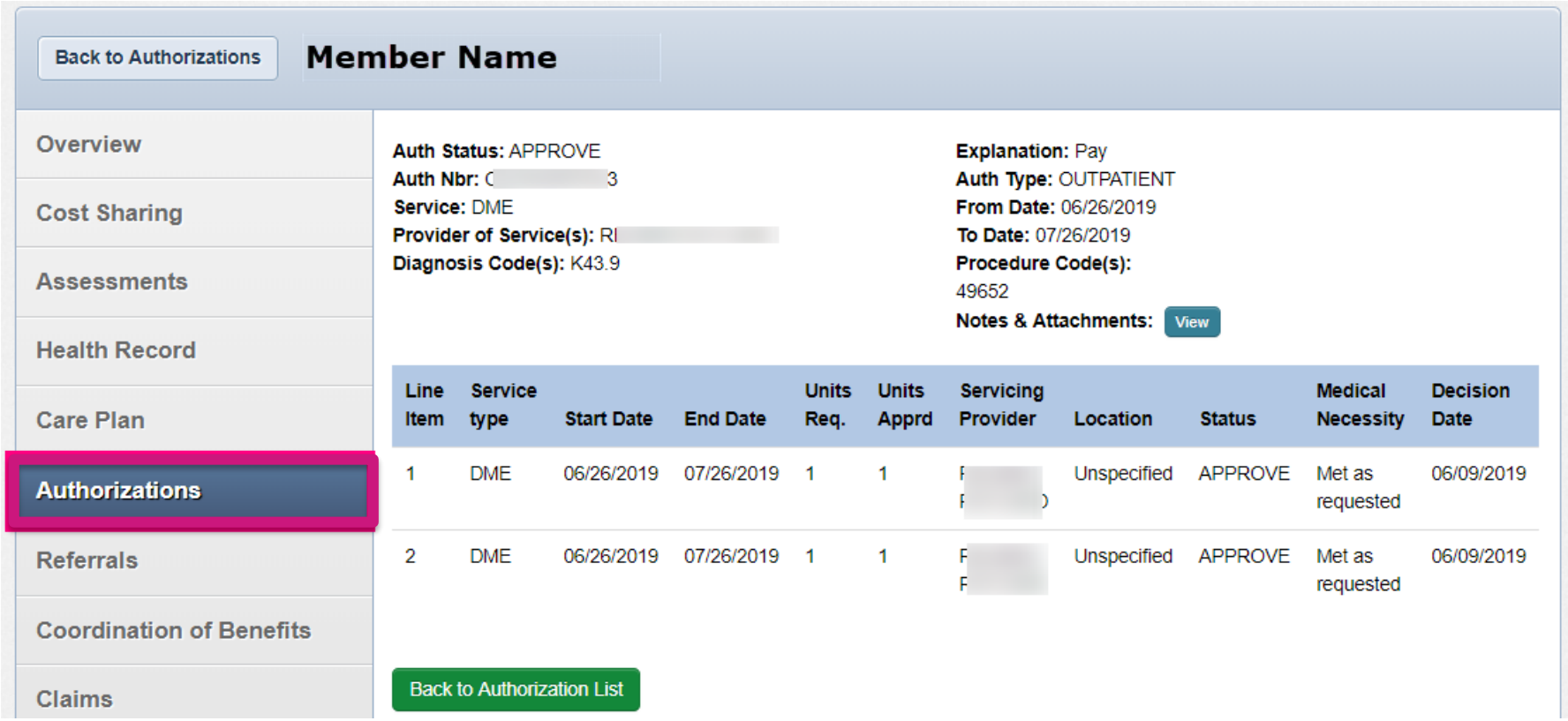
Authorizations

- View, create and filter group Authorizations.
  - Click on the **AUTH ID** to see additional information.



Authorization Details

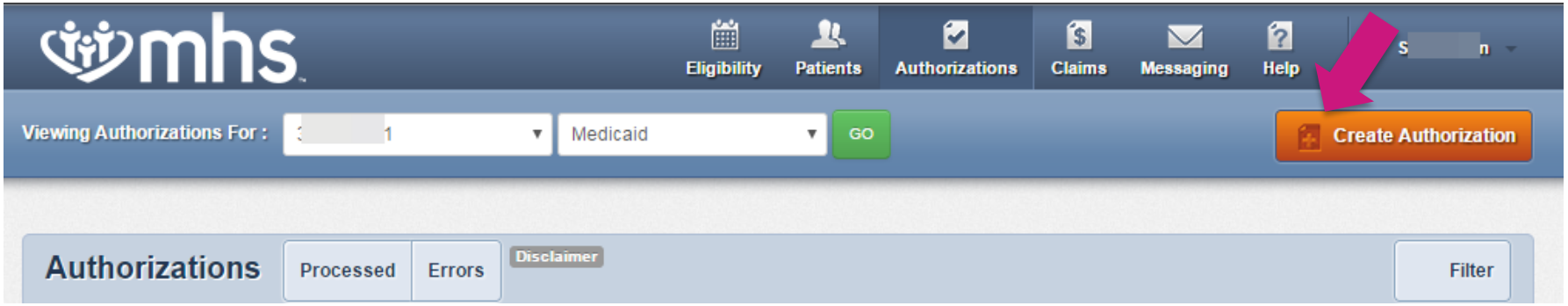
- View Auth Status, Auth Nbr, Service, Provider of Service, Diagnosis Code(s), Explanation, Auth Type, From Date, To Date, Procedure Code, and Notes and Attachments.

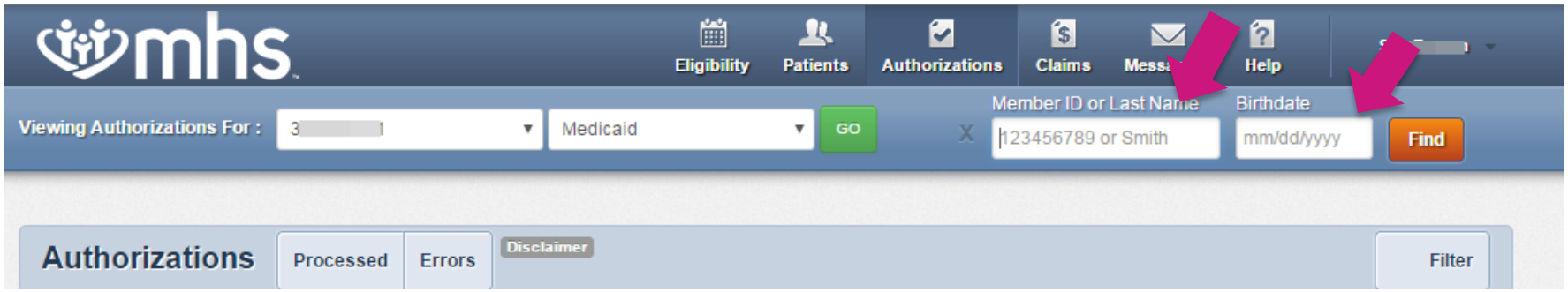


Create a New Authorization

New Authorization

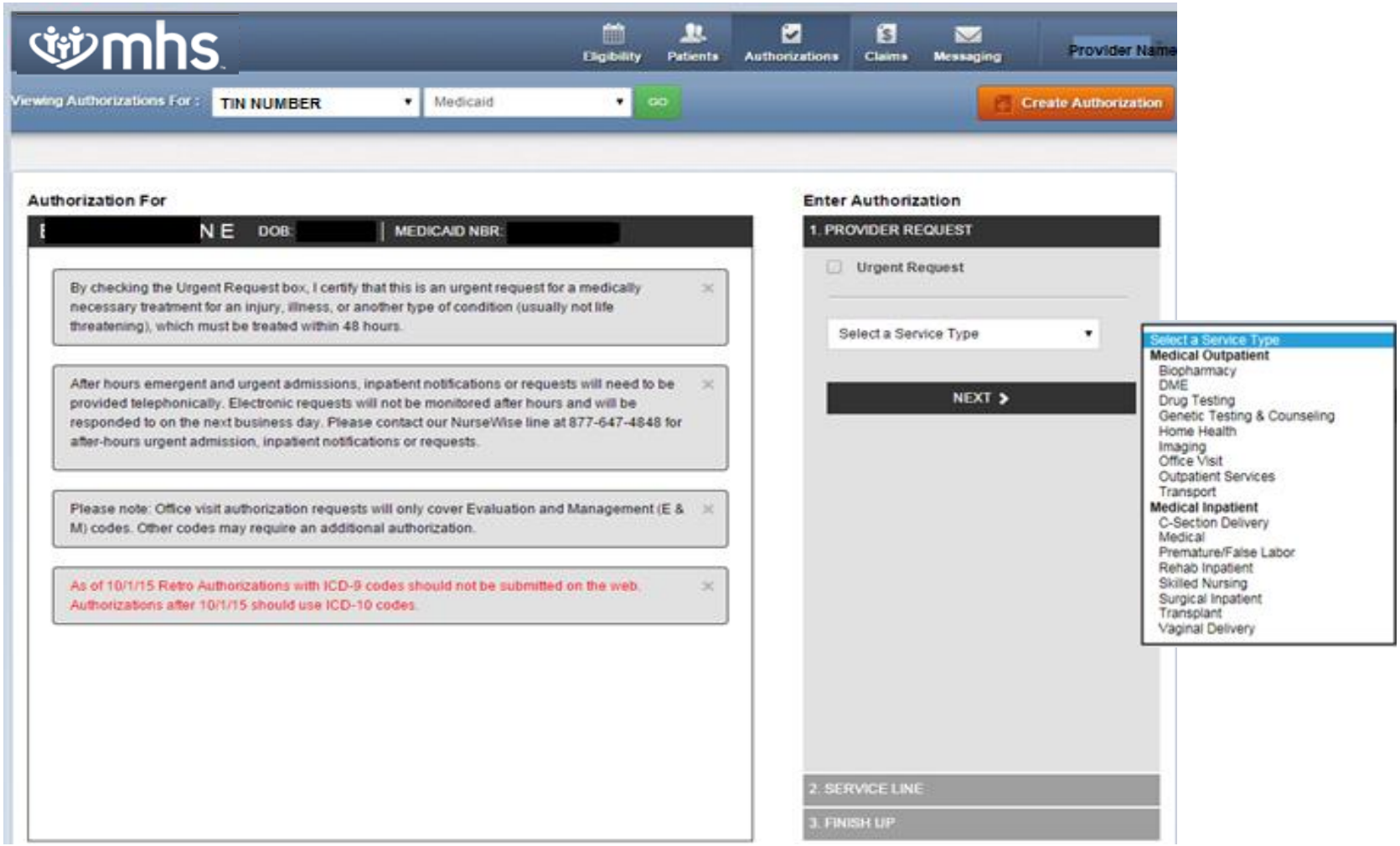
- Click **Create Authorization.**
- Enter **Member ID** or **Last Name** and **Birthdate.**





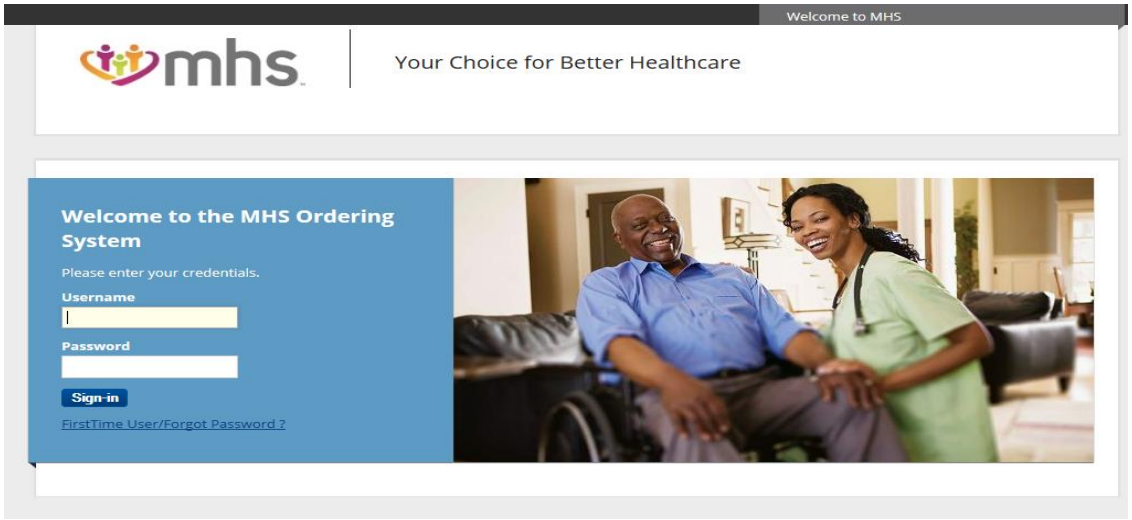
Creating a New Authorization

- Select a **Service Type.**



Authorization for Durable & Home Medical Equipment

- Requests should be initiated via **MHS Secure portal on MHSIndiana.com**
  1. Select **Authorizations** tab and click on **Create Authorization**.
  2. Enter **Member ID** or **Last Name** and **Date of Birth.**
  3. Choose **DME** and you will be directed to the Medline portal for order entry.



Claims

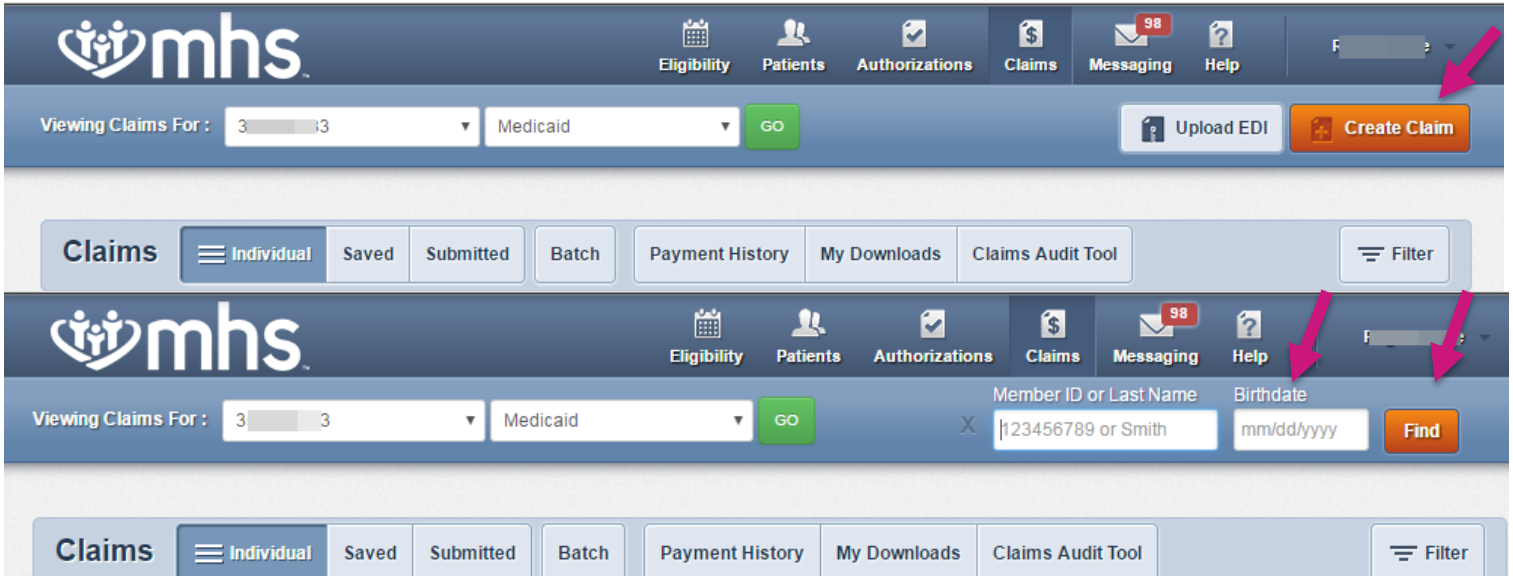
Claims

Claims Features

- **Submit** new claim.
- **Review claims** submitted for members.
- **Correct** claims.
- View **Payment History.**

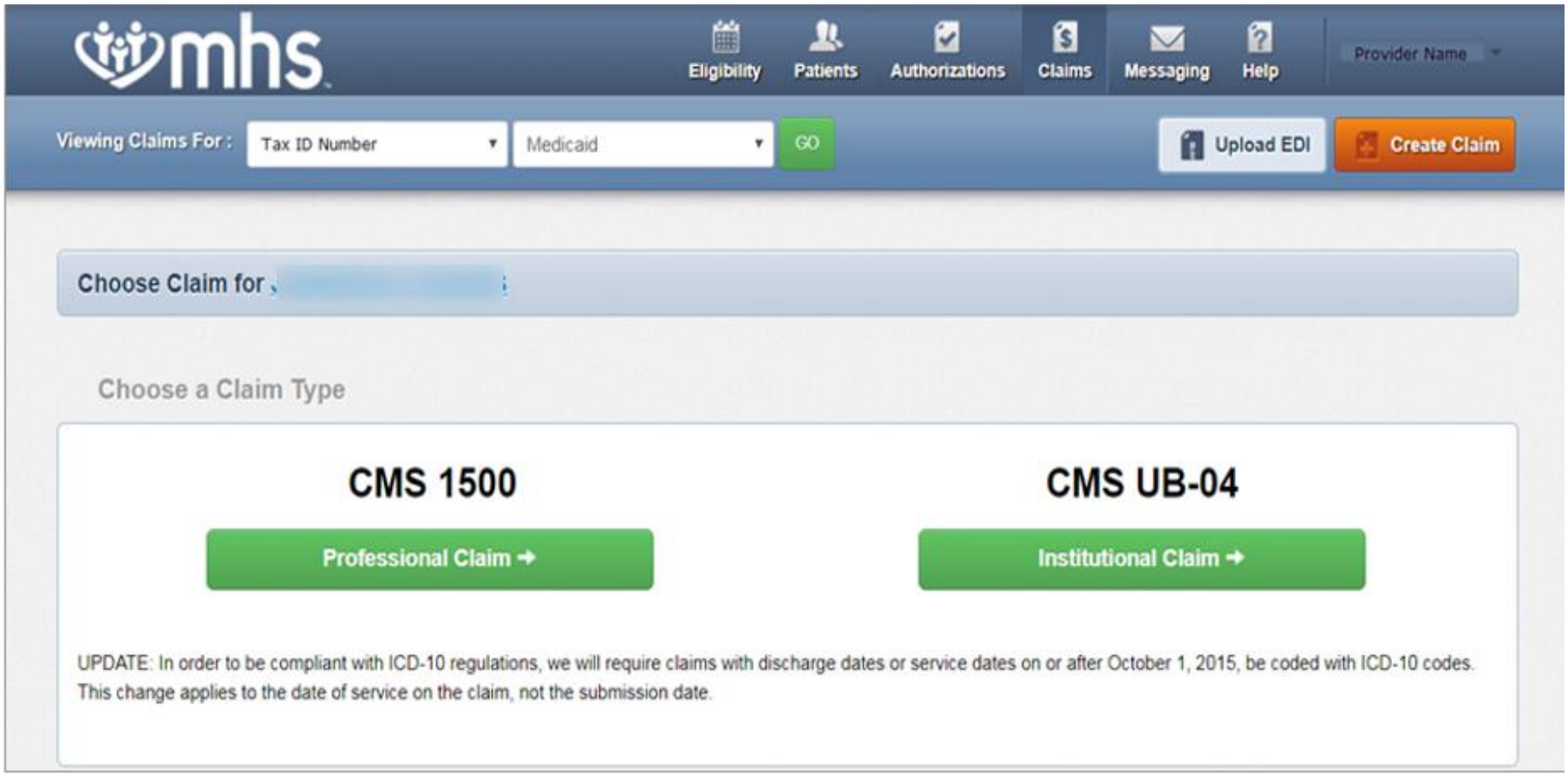
Submit a New Claim

- Click **Create Claim** and enter **Member ID** and **Birthdate.**



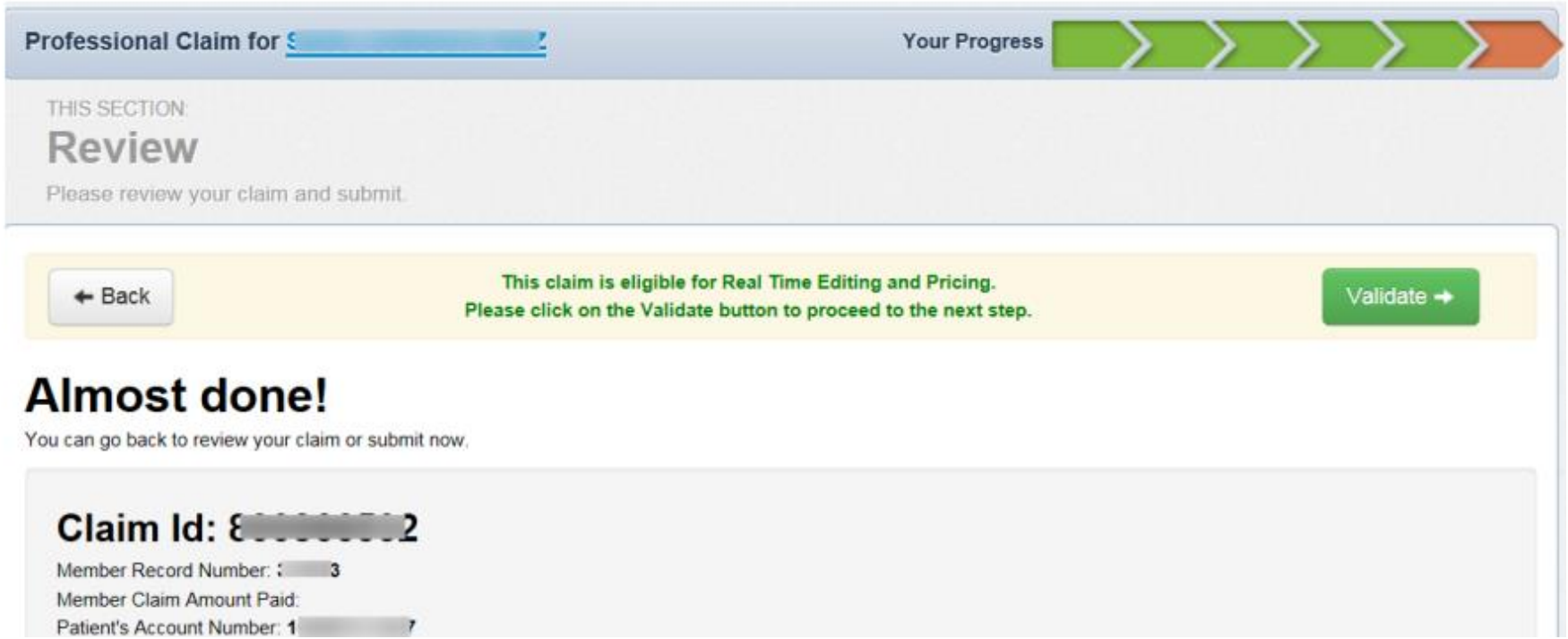
Claim Submission

Choose the **Claim Type.**



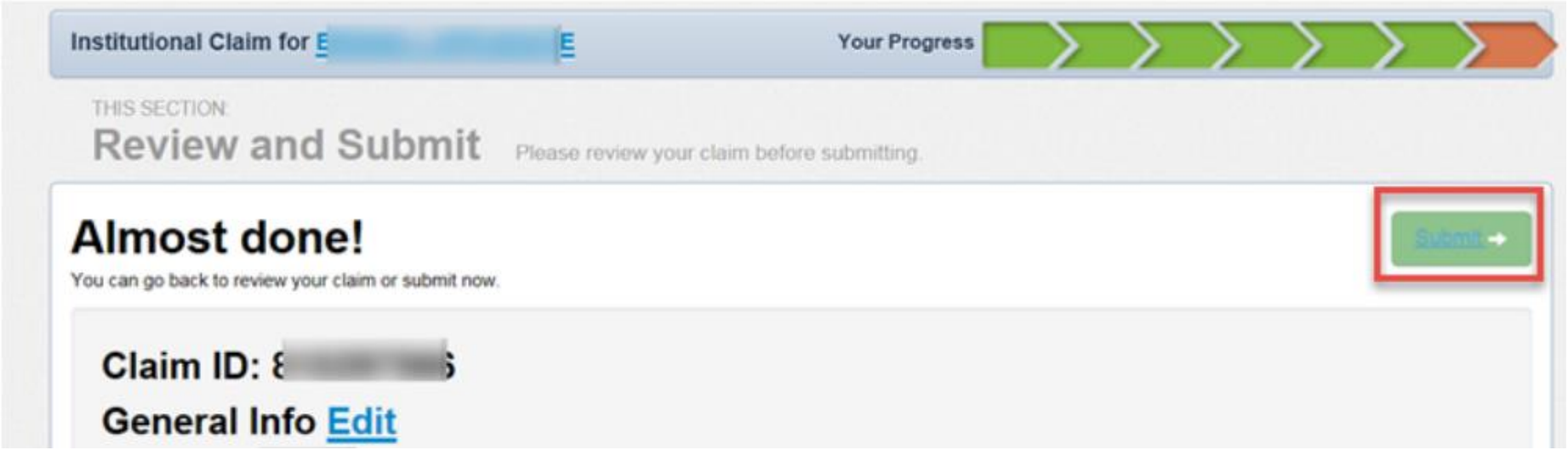
Professional Claim Submission

Follow **Your Progress** to see Professional Claim steps and Submission.



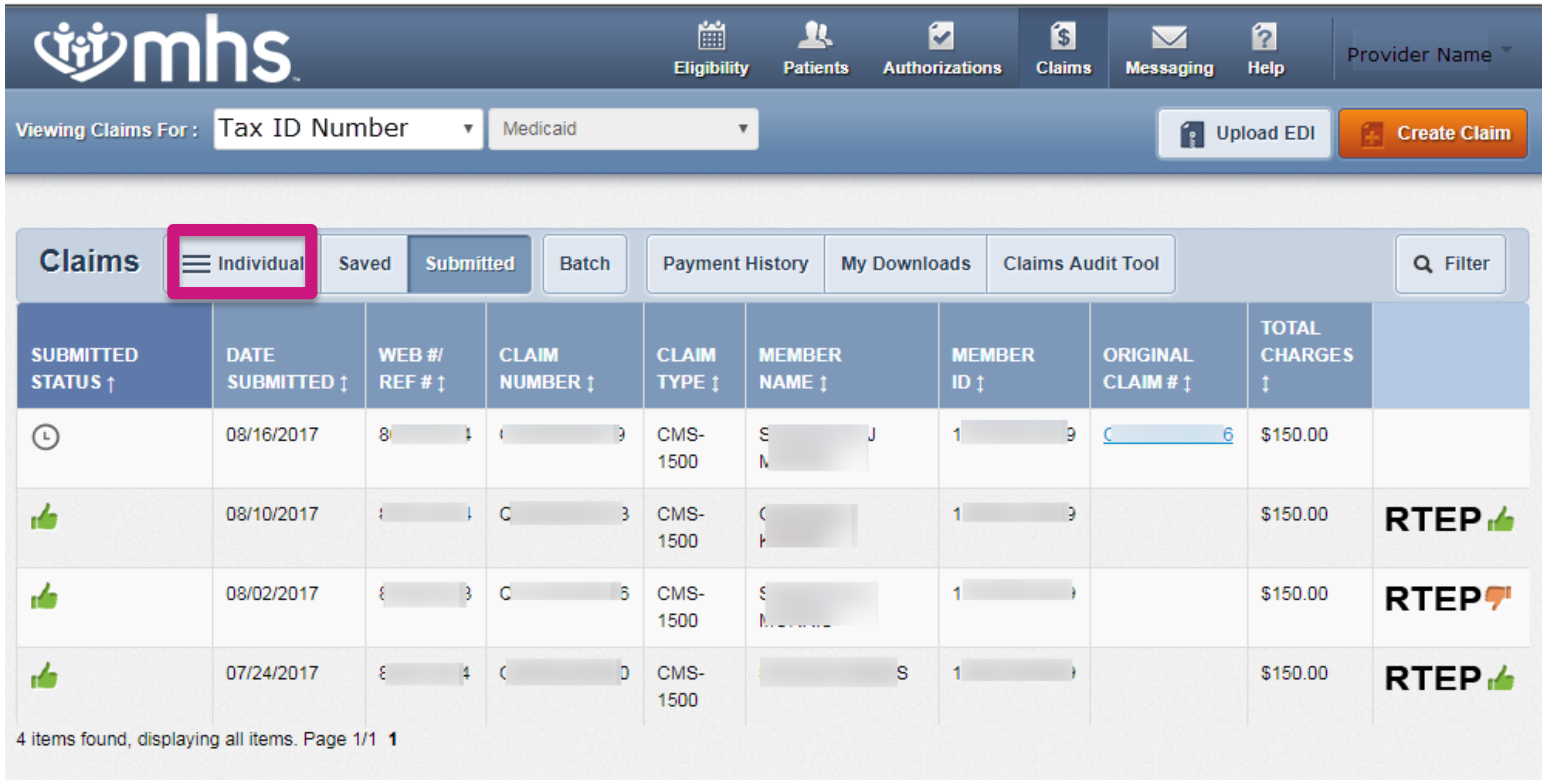
Institutional Claim Submission

- Follow **Your Progress** to see **Institutional Claim** steps and Submission.



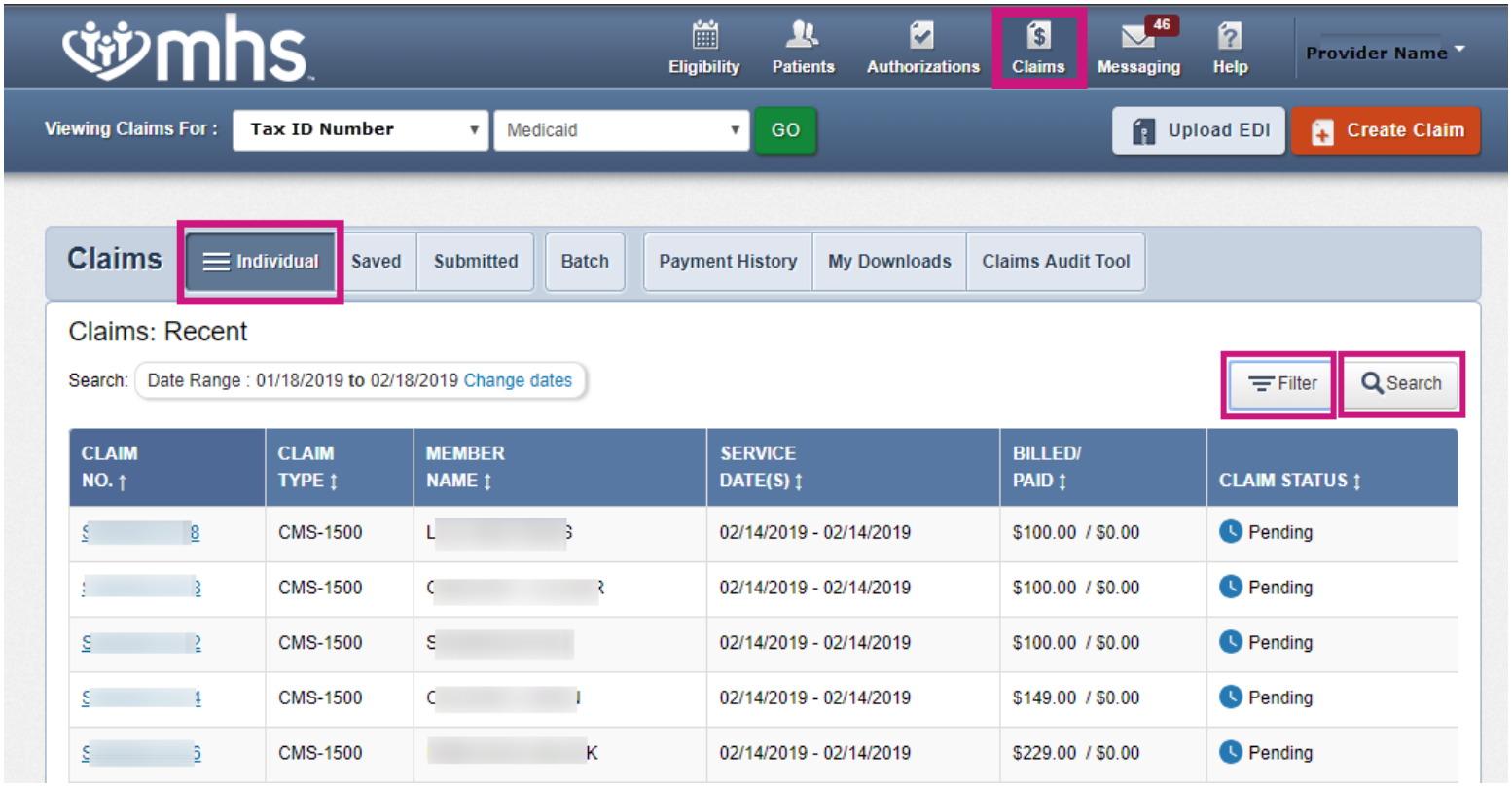
Submitted Claims

- The **Submitted** tab will show only claims created via the MHS portal.
  - **Paid** is a green thumbs up.
  - **Denied** is a orange thumbs down.
  - **Pending** is a clock.
- **RTEP (Real Time Editing and Pricing)** claims also show if eligible. (i.e. line 3 was submitted. But was not eligible for RTEP.)



Individual Claims

- On the **Individual** tab, claims submitted using paper, portal or clearing house.
  - View the Claim Number, Claim Type, Member Name, Service Dates, Billed/Paid, and Claim Status



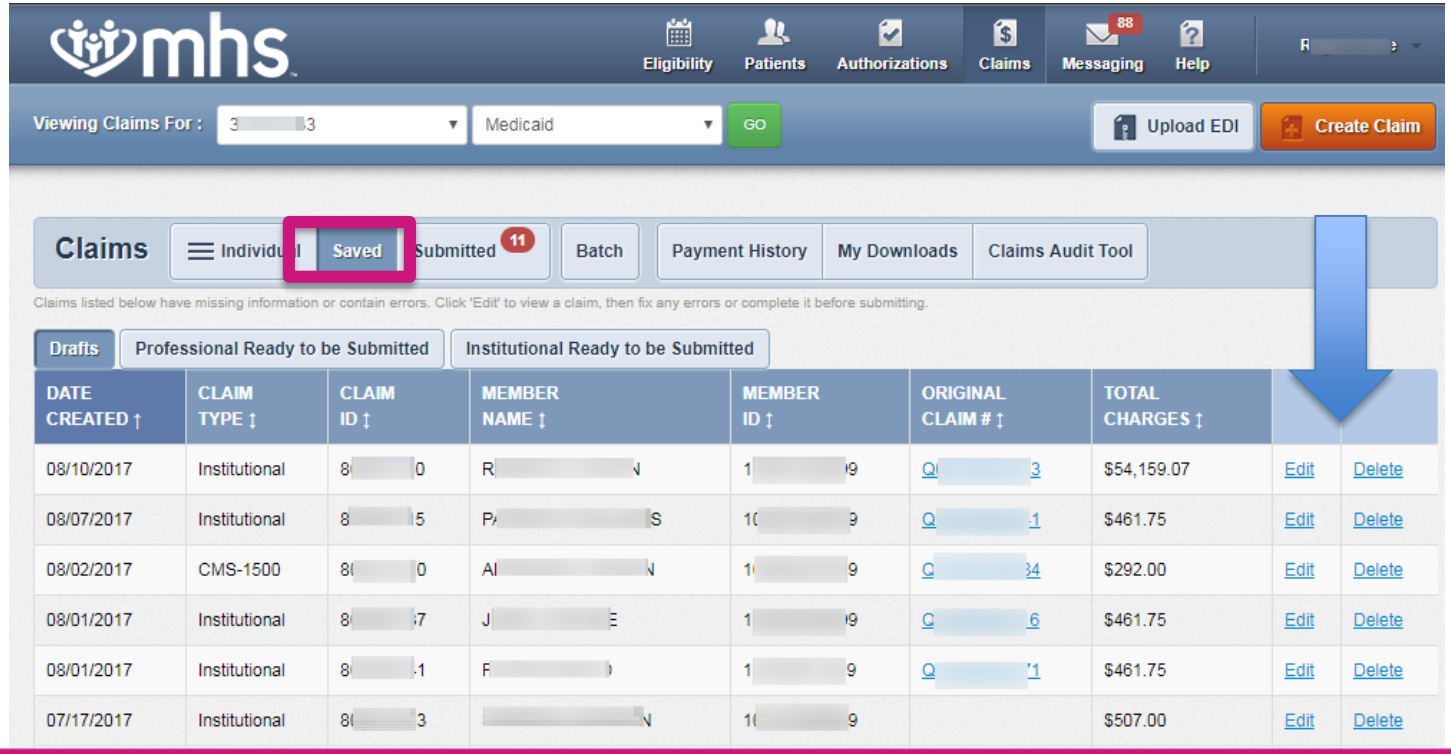
Saved Claims

To view **Saved** claims: Drafts, Professional or Institutional

1. Select **Saved.**
2. Click **Edit** to view a claim.
3. Fix any errors or complete before submitting.

   Or

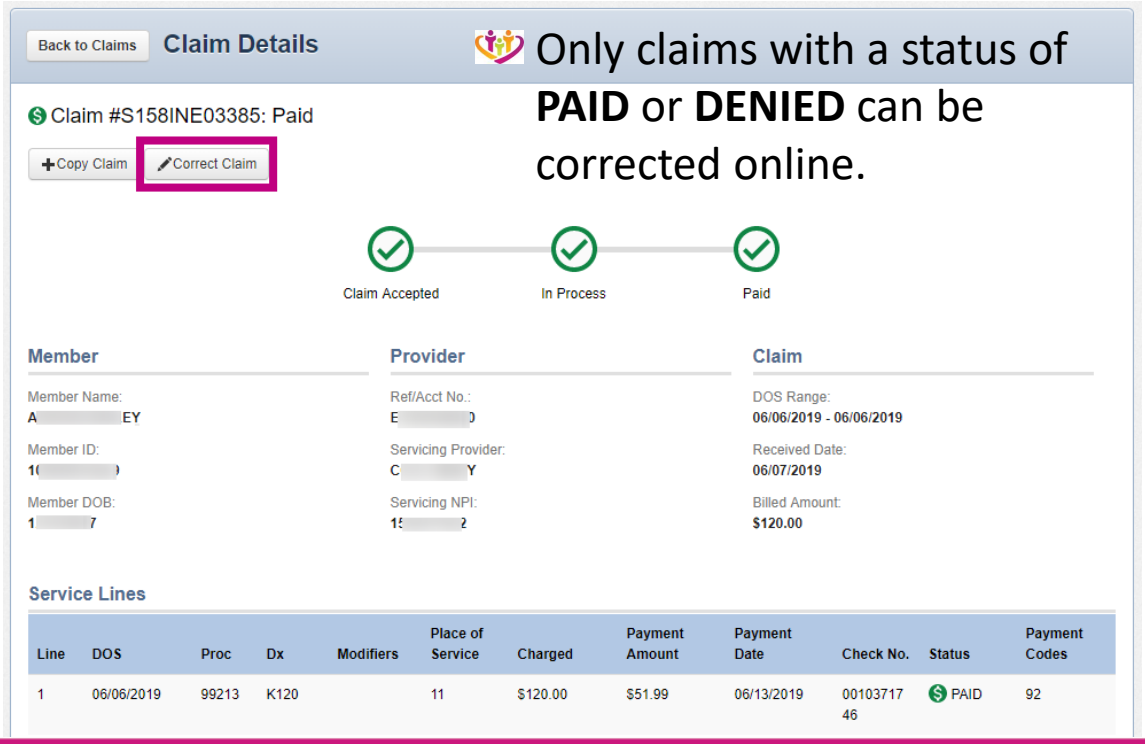
4. Click **Delete** to delete saved claim that is no longer necessary.
5. Click **OK** to confirm the deletion.



Correcting Claims

After clicking on a **Claim** # link:

1. Click **Correct Claim.**
2. Proceed through the claims screens correcting the information that you may have omitted when the claim was originally submitted.
3. Continue clicking **Next** to move through the screens required to resubmit.
4. Review the claim information.
5. Click **Submit**.

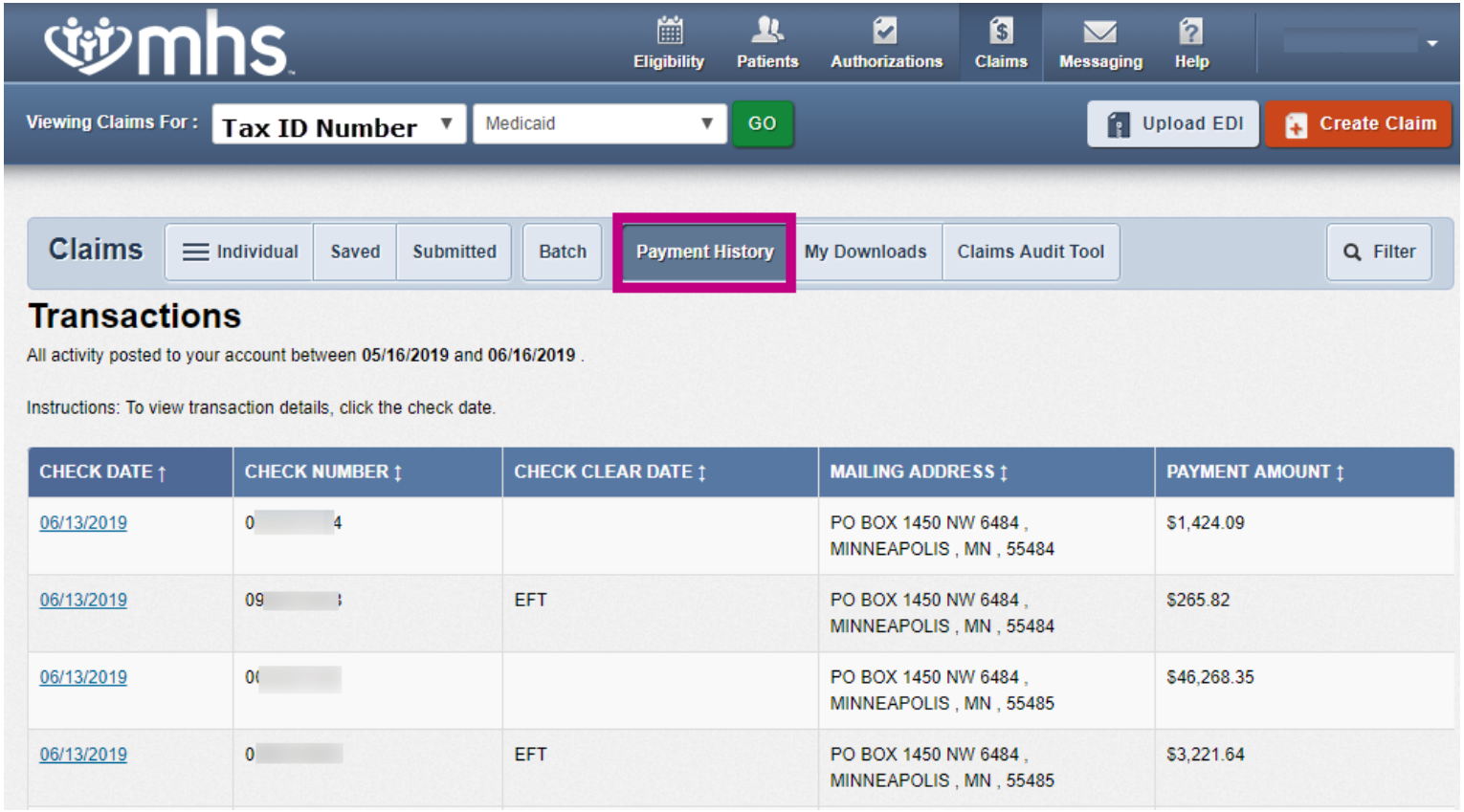


Only claims with a status of **PAID** or **DENIED** can be corrected online.

Submit a Correct Claim Guide

Payment History

- Click on **Payment History** to view Check Date, Check Number, Check Clear Date, Mailing Address and Payment Amount.
  - Click on **Check Date** to view Explanation of Payment.



Payment History

Click on **View Service Line Details.**

Explanation of Payment Details

Back to Payments List | Download (Excel Format) | Print

Check/Trace Number:[redacted] Check Date:02/28/2019

Insured Name: E[redacted]R
Patient Name: E[redacted]R
Control Number: S[redacted]9
Service Provider: F[redacted]D

Group: T[redacted]S
ID: 1[redacted]9
Account: F[redacted]
NPI: 1[redacted]9

View Service Line Details

Serv	Date	Proc#/ Proc2	Mod	Days/ Cnt Qty	Charged	Allowed	Deduct/ Copay	Coinsur	Discount/ Interest	Med Allow/ Med Paid	TPP	Denied	Remit Codes	Payment
10	02/13/2019	76820	26	0/1	100.00	24.86	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	92	24.86
20	02/13/2019	76818	26	0/1	130.00	52.32	0.00/0.00	0.00	0.00/0.00	0.00/0.00	0.00	0.00	92	52.32
Sub Total:					$230.00	$77.18	$0.00/$0.00	$0.00	$0.00/$0.00	$0.00/$0.00	$0.00	$0.00		$77.18

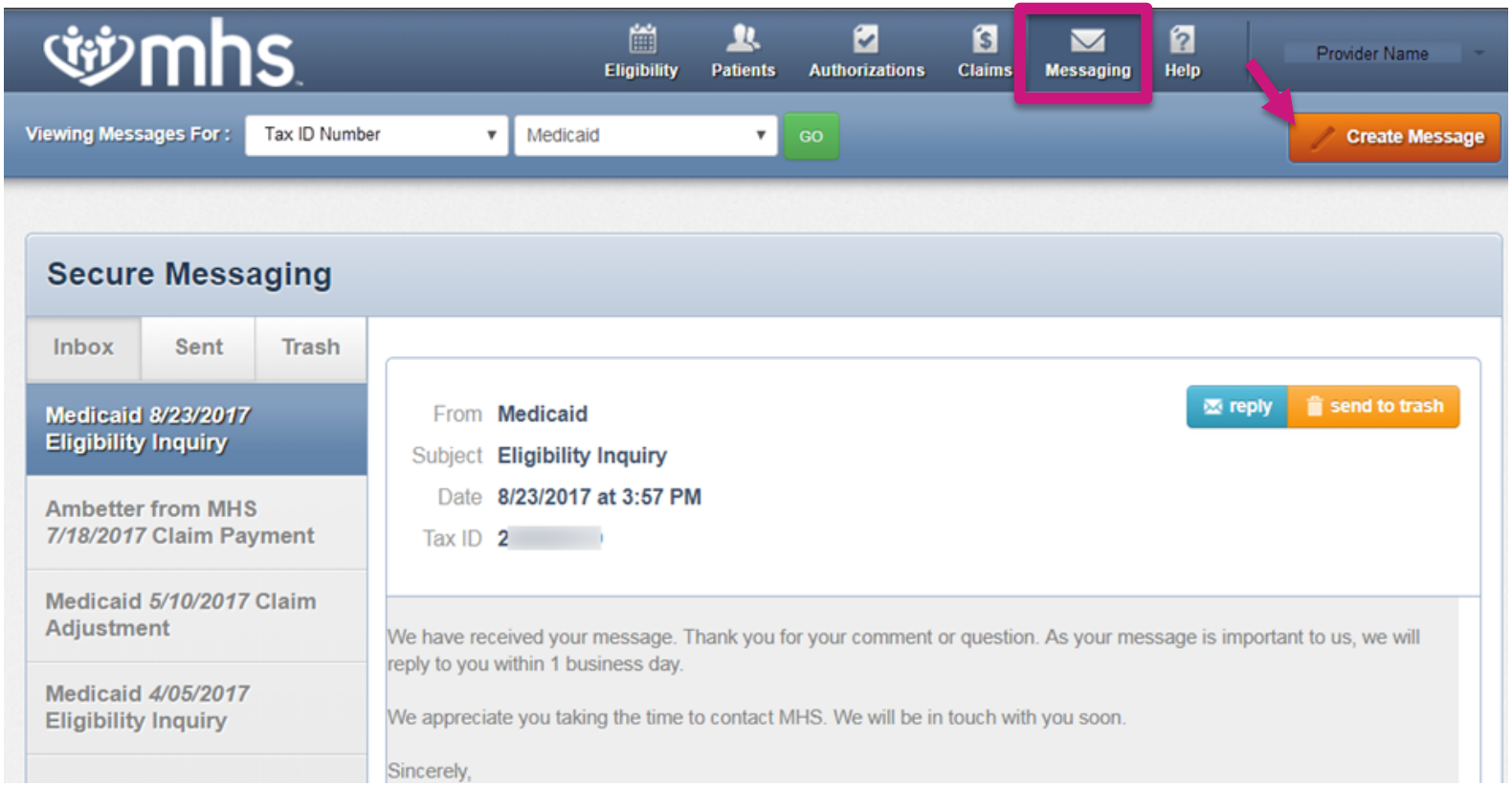
Remit Code Descriptions

92
PAID IN FULL

Secure Messaging

Create a **New Secure Message.**

- Click **Messaging** tab from the Dashboard.
- Click **Create Message.**



Provider Relations Team

MHS Provider Network Territories

NORTHEAST REGION

Claims Issues: MHS_ProviderRelations_NE@mhsindiana.com
Chad Pratt, Provider Partnership Associate
1-877-647-4848 ext. 20454
ripratt@mhsindiana.com

CENTRAL REGION

Claims Issues: MHS_ProviderRelations_C@mhsindiana.com
Esther Cervantes, Provider Partnership Associate
1-877-647-4848 ext. 20947
Estherling.A.PimentelCervantes@mhsindiana.com

NORTHWEST REGION

Claims Issues: MHS_ProviderRelations_NW@mhsindiana.com
Candace Ervin, Provider Partnership Associate
1-877-647-4848 ext. 20187
Candace.V.Ervin@mhsindiana.com

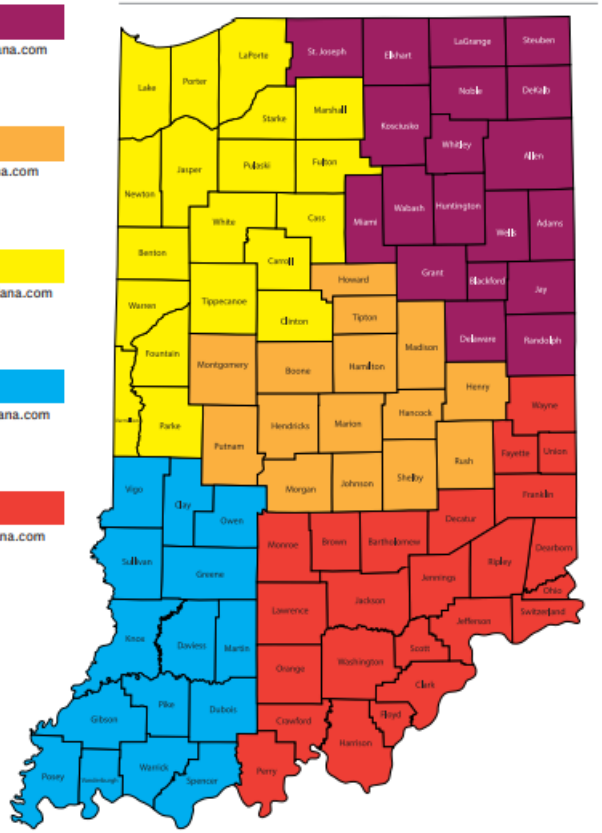
SOUTHWEST REGION

Claims Issues: MHS_ProviderRelations_SW@mhsindiana.com
Dawn McCarty, Provider Partnership Associate
1-877-647-4848 ext. 20117
Dawnalee.A.McCarty@mhsindiana.com

SOUTHEAST REGION

Claims Issues: MHS_ProviderRelations_SE@mhsindiana.com
1-877-647-4848

Indiana



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Mark Vonderheit
Director, Provider Network
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tbalko@mhsindiana.com

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Manager, Network Development & Contracting
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Director, Network Operations
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MHS Provider Network Territories

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Provider Partnership Associate II
1-877-647-4848 ext. 20022
tdanzie@mhsindiana.com

PROVIDER GROUPS
Beacon Medical Group
Community Care Network
Franciscan Alliance
Goshen Health System
HealthLinc
Heart City Health Center
Indiana Health Centers
Lutheran Medical Group
Northshore Health Centers
Parkview Health System
South Bend Clinic

JENNIFER GARNER
Provider Partnership Associate II
1-877-647-4848 ext. 20149
jgarner@mhsindiana.com

PROVIDER GROUPS
American Health Network of Indiana
Columbus Regional Health
Community Physicians of Indiana
Good Samaritan Hospital Physician Services
HealthNet
Health & Hospital Corporation of Marion County
Indiana University Health
Little Company of Mary Hospital of Indiana
Riverview Hospital
St. Vincent Medical Group

INTERNAL REPRESENTATIVES

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Provider Network Specialist
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jedean@mhsindiana.com

LAKISHA BROWDER
Provider Relations Specialist
1-877-647-4848 ext. 20224
lbrowder@mhsindiana.com

ENVOLVE DENTAL, INC.

MICHAEL J. WILLIAMS
Provider Relations Specialist
1-727-437-1832
Dental Provider Services: 1-855-609-5157
Michael.Williams@EnvolveHealth.com

What did you learn?

- Analytic/Web Tool Resources
- Navigating the web portal
- Navigating provider analytics
- How to view Gaps In Care
- Navigating patient analytics
- Eligibility verification
- Authorization requests and information
- How to submit a corrected claim
- Reviewing claim information
- How to submit request on line

Questions?

Thank you for being our partner in care.

Session Survey

- Please use the QR code or the weblink below to complete a survey about the session you just attended. Each session has a unique survey so be sure to complete the appropriate one for each session you attend. We will be taking your feedback from this survey to improve future IHCP events.

https://tinyurl.com/fssa1038